The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: JOHN E. DONLEY, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLI, No. 10 October, 1958

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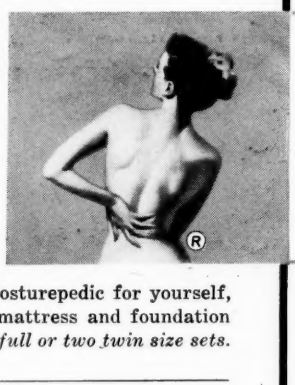

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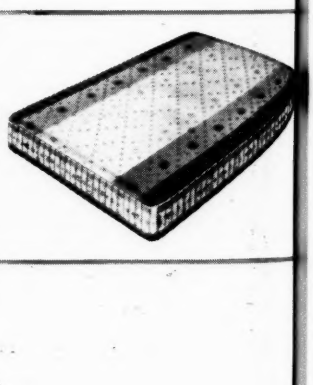

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XLI OCTOBER, 1958 NO. 10

MYOCARDIAL INFARCTION ASSOCIATED WITH SUN BATHING

JOHN C. HAM, M.D., AND ALTON M. PAULL, M.D.

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THIS DISCUSSION of an instance of two myocardial infarctions occurring in rapid succession in association with intense sun *baking* is presented for two reasons: first, the suspicion that prolonged intensive inactive exposure to hot sun's rays has more than a coincidental relationship to myocardial infarction; secondly, the hope that it will stimulate others to be on the look-out for such occurrences, eventually to determine whether or not this suspicion is borne out. Several investigators have presented evidence that exposure of the body to heat produces changes in the physical and chemical characteristics of blood in animals and man. It would seem that some of these changes might tend to slow the coronary circulation and to favor blood clotting.

Hall and Wakefield[1] found that in overheated dogs there was a rise in non-protein nitrogen and usually an increase in chloride calculated as sodium chloride. Lactic acid in the blood reached very high levels. The blood sugar varied and the pH of the blood and the alkali reserve dropped. Ferris et al,[2] found in forty-four human cases of heat-stroke moderate drop in CO_2 content of blood and hemoconcentration. Signs of heart or peripheral circulatory failure was found in some, but not in the majority.

Motta[3] found in rabbits exposed to overheating for 48 to 95 minutes the following EKG changes:

I. *Disturbances of rhythm:*—Sinus tachycardia, extrasystoles, paroxysmal tachycardia, auricular and ventricular flutter and fibrillation.

II. *Disturbances in conduction:*—1, disturbance of A. V. conduction—increase in PR interval, 2, 1° block; 2, disturbance of intraventricular conduction—widening and deformity of the ventricular complex.

III. *Disturbances of coronary circulation and myocardial function:*—accentuated q wave, elevated ST segment and sometimes negative T in Lead I.

Metz[4] cites three cases of heat stroke with EKG changes observed at varying periods of time following a long march in hot weather. The subjects were all young men, ages 22, 23, and 30 years. Symptoms included a pressure and oppressive feeling in the chest in one and loss of consciousness coming on quite suddenly in another. The EKG changes concerned mainly the T wave and ST segments. Air temperatures at the time these two men were marching varied from 15.8° to 32° centigrade, and humidity from 32-74%. The third patient showed a deep Q3, elevation of ST2 and ST3 with a negative T2 and T3, interpreted as typical of myocardial infarction.

Making a study of the incidence of myocardial infarction in different months of the year in Dallas, Texas, Heyer[5] found that the incidence was considerably higher in the months of July and August, than in the cooler months. He points out that this is the reverse of what has been found in other studies of the monthly incidence of myocardial infarction in the northern part of the United States and in states where the summer weather is not so extremely hot. The daily temperature readings in Dallas, during July and August, usually exceed 95° and often exceed 100° Fahrenheit. He suggests that the profound physiologic adjustment a person must make to preserve constant body temperature probably exerts considerable strain and may act as a precipitating factor. In none of the patients with myocardial infarction was there frank heat-stroke with hyperthermia, but a mild degree of heat exhaustion is comparatively frequent in Dallas. He reminds us that adjustment to such a hot climate

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causes increase in cardiac work, often with increased cardiac output and blood volume and deviation of a larger portion of the blood through the skin to promote heat loss. Arterial blood pressure has been shown to decrease and peripheral resistance to fall; fluid and salt loss are a result. He suspects that patients predisposed by coronary arteriosclerosis might possibly develop myocardial infarction. Also, there is the possibility of a thrombogenic state occurring, with alteration of blood coagulability.

Some years ago one of us (J.C.H.) saw a patient with advanced inactive rheumatic heart disease who was a *Sunworshiper*. One hot summer day, after he had spent a prolonged period of time baking in the sun, with a great part of his body exposed, he suffered a severe oppressive feeling in his left chest that persisted throughout the evening and prevented his sleeping. There was no drop in the blood pressure and no changes in his auscultatory findings, except for a pericardial friction rub. The pericardial friction sounds persisted for about twenty-four hours. He had varying pains, a tight feeling and sensation of oppression in his chest and the region of the left scapula for the first ten days in the hospital. The pains cleared completely and he felt well for ten days. The following day he spent part of the time lying in the sun with his chest bare. That night he developed an aching pain in the right scapula region and a feeling of tightness in the epigastrium and lower chest. Stabs of sharp pain were noted in the region of the cardiac apex, requiring morphine on two occasions. Serial EKG's were not indicative of an acute myocardial process. It was suspected at the time that the extensive heat exposure might have been a factor in this case, with involvement of his heart and/or pericardium, but the evidence was only suggestive. He was advised to avoid such strenuous sunbathing. He had no further episodes of chest pain, but died a few years later in congestive failure. Autopsy revealed inactive rheumatic heart disease with marked hypertrophy and dilatation, aortic stenosis, pulmonary embolism, an acute healing myocardial infarct, but no old infarct.

With the above-mentioned considerations in mind we cannot but be impressed with the following two attacks of myocardial infarction, occurring in rather rapid succession in a relatively young sthenic man without evidence of any factors that might predispose him to the development of coronary occlusion other than exposure to the hot rays of the sun for prolonged periods on both occasions. H.A., a fifty-year-old white man, was admitted to the Rhode Island Hospital on July 30, 1956, with the chief complaint of oppressive tightness and pressure in his anterior chest, of several hours' duration. He had been in relatively good health until the day of admission, when he suddenly developed substernal oppression soon after arising from bed in the morning. Shortly thereafter, he became weak and sweaty, developed a paroxysm of coughing, complained of a choking sensation and felt chilly.

Review of his past history revealed that he had been treated at the Rhode Island Hospital five years previously for a lung abscess.

Three years prior to admission, he developed symptoms of a peptic ulcer and remained under treatment for the next year. Since that time he had been asymptomatic. He smoked less than one pack of cigarettes a day.

The family history was non-contributory.

Physical examination revealed the patient to be a well-developed, well-nourished white, deeply tanned male.

The eyelids appeared moderately puffy. The heart was not enlarged to percussion. Rhythm was regular. There were no murmurs, friction rub or gallop. Pulse 68, blood pressure 140/100. The lungs were clear to percussion and auscultation. The remainder of the examination was not remarkable.

Examination of the blood disclosed a hemoglobin of 16.2 gm per 100 cc., with a micro-hematocrit of 50 mm. The white cell count was 34,900 with 91% neutrophils, 5% lymphocytes and 4% monocytes, dropping to 12,450 with 73% neutrophils on his third hospital day. Urinalysis and Hinton were negative. The blood urea nitrogen was 14 mg. per 100 cc. The prothrombin activity was 82% of normal. Blood cholesterol 196 mg%. Serial electro-

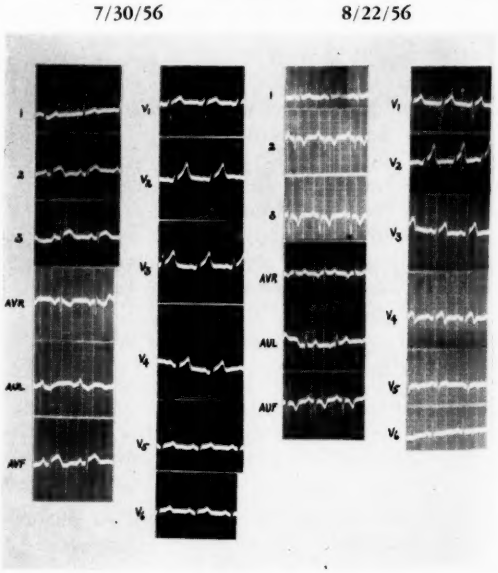

FIGURE 1

cardiograms showed evidence of postero-lateral myocardial infarction. (See Figure 1)

Course: On admission the patient complained of some chest pain, but this disappeared within a short period of time. His course was uncomplicated, except for a mild tonsillitis and moderate apprehension. Treatment consisted of three weeks of bed rest, dicumarolization and gradual ambulation. The patient was discharged on August 27, 1956, without dicumarol.

Following discharge, he returned to his home and gradually resumed mild activity. Most of his time was spent lounging around, doing nothing in particular. He continued to feel well until three days prior to his second Rhode Island Hospital admission, when, after eating a light meal, he suddenly developed a substernal squeezing, oppressive feeling with radiation to the neck, left shoulder and epigastrium. He was readmitted to the hospital.

Physical examination on his second admission 9/7/56, was not remarkable except for some tenderness in the epigastric region. Significant laboratory data included a white blood count of 14,9000 with 71% neutrophils and a sedimentation rate of 35 mm. per minute. The electrocardiogram was indicative of a fresh anterior myocardial infarction (Figure 2).

9/20/56

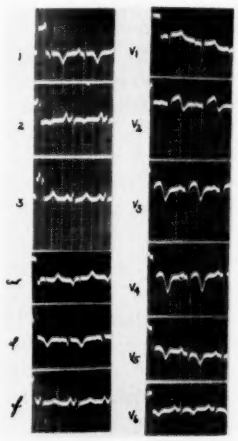

FIGURE 2

Course: Again the patient was placed on strict bed rest and treated with dicumarol. On the third hospital day his temperature suddenly rose to 101.4° F. He developed a moderate cough productive of some thin mucoid sputum. The essential finding on physical examination was the presence of a moderate number of medium crepitiant rales at both bases posterially. It was felt that he had developed a pneumonitis and he was given Achromycin, with prompt subsidence of his temperature and symptoms. The remainder of his hospital stay was uncomplicated. A chest X ray and fluoroscopic examination of his chest prior to discharge revealed slight left ventricular enlargement. He was discharged on October 6, 1956.

It was later learned that on the day prior to his first admission, he had spent several hours sunbathing, wearing only bathing trunks. During this time he had perspired freely, but later on experienced chilly sensations. The next morning he developed a paroxysm of coughing while drinking his orange juice. Following this bout of coughing, he developed a poorly localized pressure sensation in the anterior chest, but no definite chest pain. Because he had difficulty in breathing, his physician was summoned and sent him to the hospital. Immediately prior to the second attack, one week after discharge from the hospital, he again sunbathed for 1½ to 2 hours, perspired profusely and felt chilly. Again he choked and coughed while eating. He had similar sensations of inability to get his breath and pressure in his chest, but not so severe as on the first occasion. He was put to bed by his physician, and three days later was seen by one of us (J.C.H.) and readmitted to the Rhode Island Hospital.

For several years he had been accustomed to a great deal of sunbathing, but he never had the pronounced symptoms he had on these two occasions.

Since his final discharge from the hospital, he has gradually increased his activity and has returned to his usual occupation as a commercial artist, but has restricted his work so as to avoid being put under pressure to meet deadlines or to do any rush work. Except for one spell of nausea and faintness, with rapid heart rate when exposed to

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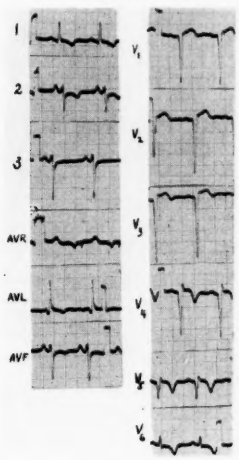

FIGURE 3

GASTROINTESTINAL HEMORRHAGE DURING TREATMENT WITH RAUWOLFIA ALKALOIDS*

JANIS GAILITIS, M.D., JOHN B. NALLY, M.D.,
LOUIS E. BURNS, M.D., AND ROBERT B. MOTOLA, M.D.

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ALTHOUGH Rauwolfia serpentina and its alkaloids are widely used as anti-hypertensive and tranquilizing agents, serious side reactions are infrequent. However, instances of hematemesis and melena have been reported, mostly in psychiatric patients taking high doses of these drugs.[1-4] The safety of "standard" doses of Rauwolfia preparations used in the treatment of hypertension has been emphasized.[5] During the last two years, in a two-hundred bed community hospital, five patients with hypertensive and cardiovascular disease, receiving reserpine or Rauwolfia, developed upper gastrointestinal hemorrhage. The dosage was within the accepted range, not exceeding 1 mg. reserpine daily.

Case 1: A sixty-one-year-old white housewife was admitted to the hospital on July 6, 1956 for treatment of high blood pressure and obesity. Marked shortness of breath and edema of the legs had developed about seven months previously. Later the skin of the legs began to break down and sleeping in a supine position became impossible. The patient had spent the last five months in a chair; since January 13, 1956 she had been taking reserpine, .25 mg.-pyrrobutamine 7.5 mg. (four tablets daily).

Although there had been little response, this dosage was continued until the day of admission. There had been frequent episodes of indigestion with discomfort in the upper abdominal area, relieved by belching. She was extremely apprehensive. Her weight was estimated to be over 300 pounds. She was unable to sit up or turn in bed. Blood pressure ranged from 185/85 to 260/110. Pitting edema and weeping skin lesions of both legs were observed. The heart was moderately enlarged and the sounds muffled.

Hemoglobin 11.6 gm. per 100 ml., red blood cells 4.4 million per cu. mm. Urinalysis revealed a slight trace of albumen. There were 25-30 red blood cells per high power field.

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Treatment

The patient was placed on an 800 calorie, low sodium diet; reserpine .25 mgs. was given four times daily.

Her progress on this regimen was unsatisfactory and death occurred suddenly on July 13, 1956, one week after admission. The following significant findings, pertinent to this presentation were revealed at the autopsy: The esophagus, stomach, and small intestines contained red, clotted blood. The clots were loosely attached to the inner surface of the stomach, on which there were a few superficial ulcers, evidence of a diffuse gastritis. Microscopic examination showed a severe, acute hemorrhagic gastritis. There was evidence of aspiration pneumonia (gastric contents and blood).

Comment

This patient, suffering from hypertensive cardiovascular disease, developed frequent episodes of indigestion after treatment with reserpine was started. Her complaints were not properly evaluated and the rather high dosage of reserpine (1 mg. daily) was continued. Death occurred six months later from a hemorrhage caused by acute erosive gastritis.

Case 2: A sixty-one-year white male entered the hospital on September 13, 1957 complaining of hematemesis and abdominal pain. He had suffered from indigestion for many years. In February 1954 he was admitted to the hospital for treatment of a duodenal ulcer; the diagnosis was confirmed by X-ray studies. On March 2, 1954, .25 mg. of reserpine four times a day was prescribed because of moderately severe hypertension (blood pressure 220/120). His response was favorable and later the dosage of reserpine was reduced to .25 mg. three times daily. In January 1956 his blood pressure was still elevated. Reserpine was discontinued and reserpine .25 mg.-pyrrobutamine 7.5 mg. three tablets daily was substituted. This medication was continued until the day of admission, the dosage ranging from 1 to 4 tablets daily. He had not followed any dietary regimen. Occasionally, he had taken aluminum hydroxide gel for relief of ab-

dominal pain. During the last four to five weeks epigastric pain had been almost continuous and had increased in severity. There had been several tarry stools. Three days prior to admission, he vomited about 500 cc. of blood. Physical examination revealed a pale, lethargic male. Temperature was 100.6 F., pulse 100, respirations 26, blood pressure 200/110 and weight 187 pounds. The heart was slightly enlarged to the left. There was some epigastric tenderness and muscle guarding. The liver edge was palpable two finger breadths below the right costal margin. Hemoglobin was 8.3 gm. per 100 ml. and hematocrit 25 per cent. He was treated with the Sippy regime. Two days after admission he vomited 300 cc. of blood. The blood pressure was 150/90, the skin was cold and clammy and the NPN was 72 mgs. per 100 ml. Prompt improvement was observed after transfusion of 1,000 cc. of whole blood. Two weeks after admission, X-ray studies revealed a duodenal ulcer deformity without a definite crater. The electrocardiogram showed evidence of an old posterior myocardial infarct. Conservative ulcer regime was continued. Although the blood pressure remained elevated, treatment with reserpine was not resumed.

Comment

Hemorrhage from a duodenal ulcer occurred while the patient was receiving reserpine for the treatment of hypertension. Bleeding stopped and ulcer symptoms subsided with medical management. Reserpine was contraindicated because of the known ulcer history.

Case 3: A seventy-six-year-old white female was admitted on July 17, 1957 because of hematemesis and melena of two hours' duration. Several years previously she had been treated for myocardial infarction and high blood pressure. For the past two years she had received reserpine .25 mgs. three times a day. There was no previous history of symptoms related to the gastrointestinal tract. She was very pale and obese; the skin was cold and clammy. The pulse was 100, blood pressure 220/100. She continued to vomit blood and two hours later the hemoglobin was 8.9 gm. per 100 ml. and the hematocrit 20 per cent. The NPN was 105 mgs. per 100 ml. Urinalysis was within normal limits. 5000 cc. of blood were given over a period of four days. At the end of this time the bleeding stopped and her condition was greatly improved. The hemoglobin was 11.9 gm. per 100 ml. and the hematocrit 33 per cent. The NPN was 55 mgs. per 100 ml. X-ray studies, twelve days after admission, revealed no abnormality of the upper gastrointestinal tract. The electrocardiogram showed evidence of an old myocardial infarction. Although her blood pressure remained elevated, treatment with reserpine was not resumed.

Comment

Massive upper gastrointestinal hemorrhage in a patient with hypertensive cardiovascular disease after prolonged use of reserpine. No premonitory digestive symptoms. Recovery on medical management, following cessation of reserpine therapy.

Case 4: A sixty-two-year-old white male was admitted on September 26, 1957 because he had collapsed in his bathroom after passing a tarry stool. In falling, he injured his forehead and left shoulder. His blood pressure had been elevated for a number of years. Two years ago he suffered a cerebrovascular accident that left him with a partial paralysis. At that time reserpine .25 mg., twice daily was prescribed and this schedule was continued until the day of his admission. There were no symptoms related to the gastrointestinal tract. Physical examination revealed an elderly male in a state of shock. The pulse was 100 and blood pressure 90/50. There was a three-inch-long laceration above the left eye, and paresis of the left side of the face. A few crepitant rales were heard over the right lung base. The liver edge was palpable two finger breadths below the right costal margin. There was no abdominal tenderness. Muscle tone on the left side of the body was increased and tendon reflexes were hyperactive. The hemoglobin was 12.7 gm. per 100 ml., hematocrit 40 per cent and NPN 63 mgs. per 100 ml. He was treated with a bland diet and blood transfusions. On the day following admission he vomited approximately 500 cc. of fresh blood. His blood pressure fell to 70/50, hemoglobin was 8.2 gm. per 100 ml. and hematocrit 27 per cent. 1500 cc. of blood were given over a period of two days, with marked clinical improvement. The bleeding ceased. On September 30, four days after admission, X-ray studies of the upper gastrointestinal tract were carried out. No abnormalities were found. Barium enema and a sigmoidoscopy revealed normal findings. There was some impairment of liver function. BSP test showed 20 per cent retention of dye, in 45 minutes. Total protein was 4.86 gm. per 100 mg., albumen 2.8 gm., and globulin 2.06 gm. per 100 ml. Cephaline flocculation 11, thymol turbity 2 units, alkaline phosphatase 5.1 Bodansky units. He was discharged, without bleeding, four weeks after admission. Although moderate hypertension persisted, treatment with reserpine was discontinued.

Comment

Upper gastrointestinal hemorrhage after two-year treatment with reserpine for hypertension. No previous symptoms related to the digestive system. Some impairment of liver function, but no evidence of esophageal varices. The site of the intestinal hemorrhage was not found.

Case 5: A sixty-eight-year-old male was ad-

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mitted on April 7, 1957 for clinical study. On the previous day he had become dizzy and faint while driving a car. At home he had to lie down on account of weakness. There had been two tarry bowel movements. He was known to be an extremely nervous individual and suffered from high blood pressure for the past seven years. In 1952 his blood pressure was recorded as 212/94. He was taking whole root of Rauwolfia serpentina, 100 mgs. every twelve hours, since that time. Lately he complained of episodes of indigestion and had been given antacids, with symptomatic relief. Physical examination revealed a pale, apprehensive elderly male. The skin was dry and warm. Blood pressure was 130/80, pulse 100; the heart was slightly enlarged to the left; an apical systolic murmur was heard. On palpation there was slight tenderness in the epigastric area. Hemoglobin was 9.4 gm. per 100 ml.; red blood cells 3.6 mill./cu. mm. He was given a bland diet, sedatives and blood transfusions. 2000 cc. of blood were given during the next three days. His condition stabilized and the bleeding stopped. X-ray studies of the upper gastrointestinal tract, four days after admission, revealed a slightly deformed duodenal bulb. On April 18, 1957 a subtotal gastrectomy was performed. An ulcer was found just beyond the pyloric ring. The pathologist reported that the ulcer was not included in the resected specimen and microscopic examination revealed no significant abnormalities.

Comment

Hemorrhage from a duodenal ulcer in a patient with hypertension who was receiving whole root of Rauwolfia serpentina. No history of pre-existing gastroduodenal disease. Recovery on medical management. Subtotal gastrectomy was performed later.

Discussion

The sequence of events, as observed clinically, in these five cases appears to parallel laboratory findings. In dogs, gastric motor and secretory activity are stimulated by reserpine.[6] In man, reserpine given intravenously, or in large doses orally, has been shown to increase the volume and acidity of the gastric secretion.[7-9] Much controversy exists regarding the effect of reserpine on gastric secretion, when given orally in doses of 1 mg. or less. In most studies no increase in gastric secretory activity was noted.[5, 9] However, daily doses of reserpine of 2 mg. or more, unquestionably augmented the volume and acidity of gastric secretion.[9] Kirsner[12] noted moderate increase in basal gastric secretion in one of eight normal persons receiving 1 mg. of reserpine per day, orally for twelve weeks. There appears to be a considerable variation of response to these compounds. This probably explains why only occasional patients, receiving standard doses of reserpine, show increased gastric secretory activity. Clinical observations have demonstrated that the administration of reserpine has been, at times, associated with reactivation of previously asymptomatic peptic ulcer.[1, 10] Hussar and Bruno[11] observed three cases of duodenal ulcer developing during prolonged administration of large doses of reserpine orally. Upper gastrointestinal hemorrhage during treatment with reserpine or Rauwolfia has been reported.[1-5] In some instances, this complication was associated with demonstrable peptic ulcer; in others, the exact cause of the bleeding was not established but acute erosive gastritis was suspected. Considering the number of patients receiving Rauwolfia serpentina, or its alkaloids, for one condition or another, the incidence of upper gastrointestinal hemorrhage appears to be low. Our five cases represent twelve per cent of all instances of upper gastrointestinal hemorrhage not caused by esophageal varices, which were treated in the Newport Hospital during the last two years. It has been said that reserpine given in daily doses of 1 mg. or less does not stimulate gastric secretory activity and is not associated with the development or reactivation of a peptic ulcer. Our experience seems to indicate that even such small quantities of reserpine, when administered for prolonged periods of time, may precipitate these complications and upper gastrointestinal hemorrhage. The side effects caused by Rauwolfia alkaloids should be remembered whenever these drugs are prescribed for long-term treatment. Even small doses may produce dangerous complications in susceptible individuals. The indiscriminate use of these agents should be discouraged. They seem to be contraindicated in patients with known, or a suggestive history of peptic ulcer disease. When used for the treatment of hypertension, the smallest effective doses should be employed, as a rule not in excess of .25 mgs. reserpine daily. Patients receiving Rauwolfia alkaloids should be closely observed for the appearance of digestive symptoms suggesting the development of peptic ulcer or gastritis. If such symptoms occur, a regimen of diet and nonabsorbable alkali should be prescribed to neutralize gastric acidity. Since anticholinergic compounds do not seem to counteract the reserpine induced gastric hypersecretion, reliance on them alone for protection is inadequate. If "indigestion" persists, the dosage of Rauwolfia alkaloids should be reduced or, if possible, these agents should be omitted. In every case of upper gastrointestinal hemorrhage, inquiry about treatment with Rauwolfia drugs should be made. If the patient has a history of hypertension, it is very likely that these compounds have been used. If upper gastrointestinal hemorrhage develops during treatment with Rauwolfia alkaloids, medical management should be favored,

especially if there is no demonstrable ulcer. The fact that the administration of these drugs in standard oral doses, is associated with gastrointestinal hemorrhage only in an occasional patient, indicates that individual susceptibility is an important determining factor.

SUMMARY

Five cases of upper gastrointestinal hemorrhage occurring during treatment with Rauwolfia alkaloids are presented. A causal relationship is suggested. The dosage was within the accepted range for alleviation of hypertension. The existence of an individual susceptibility to these alkaloids is postulated.

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the odor of paint and turpentine in a hot studio, he has to date had no symptoms referable to his heart or to any organ system. He has felt well and doesn't tire unduly. Electrocardiographic tracings have shown no further myocardial damage (Figure 3) but a persistent abnormality, suggestive of ventricular aneurysm is present.

Discussion

Two myocardial infarctions occurred in rather rapid succession, in an otherwise healthy, relatively young man. Each followed oppressive sedentary exposure to the sun. This, by no means, indicates that the sun exposure was the determining factor in causing coronary occlusion. However, the time relationships appear to suggest that it may have been.

That such exposure might be a significant factor is further suggested by the observations already cited: 1. Ferris' statement that certain blood changes, including hemoconcentration, occur in man under conditions of exposure to excessive heat. 2. Motta's experiments revealing that rabbits exposed to overheating, showed EKG changes indicative of, among other disturbances, disturbance of coronary circulation. 3. Metz's description of comparable changes occurring in man following a long march in hot weather. 4. Heyer's observation in Dallas, Texas, that myocardial infarction is more common in the hottest months of July and August than in the cooler months of the year.

It appears to us that our case, taken in conjunction with the experimental and clinical observations mentioned, gives suggestive evidence that prolonged bare exposure to extreme heat from the sun, even without physical exertion, predisposes certain individuals to the development of myocardial infarction. Whether this predisposition might be a result only of the heat generated in the body or whether there are also some other effects from the sun's rays that might produce undesirable blood changes is not clear. Whatever the factors may or may not be, we know of no beneficial effects from deliberate, prolonged sedentary sunbaking of the human body that warrant continuation of such a practice. This does not imply that moderate sunbathing is detrimental.

We hope that other observers will be on the lookout for further evidence that may confirm or negate our suspicion.

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ADJUNCTIVE SURGERY IN SUPPORT OF RADIATION THERAPY FOR CARCINOMA OF THE CERVIX

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THE RHODE ISLAND HOSPITAL has been vitally interested in the treatment of cancer of the cervix for more than thirty years.

Our interest in, and concern for this subject was initiated by Dr. Herman Pitts and Dr. George Waterman in 1922. At that time they established the Gynecological Tumor Clinic. In 1925, Dr. Pitts, then Director of Gynecology, visited Dr. Donaldson's clinic in London and saw there at firsthand, and for the first time, the use of long interstitial needles for the treatment of cervical cancer. He obtained a supply of these needles and began the treatment of this disease in Providence the following year. Four years were required to develop an acceptable technique and to become aware of the physical factors of radiation. In 1926 the method of interstitial radium application, as practiced in our hospital today, was first definitely standardized.

During the last thirty years several changes have been made in dosage and filtration; we have added deep X ray and lower mid-line lead screening and further we have repeatedly devoted ourselves to maximum treatment in one application with protraction as our protector. All of these changes have led to improvements in five-year salvage, and we now have a series of close to 1500 patients to report who were treated by this method.

These needles are a variation of the old French or Belgian needles, and they satisfy all of the requirements of Regaud's Paris clinic in that they are long, of low intensity, heavily filtered, and so calibrated as to deliver a cancericidal dose in 168 hours. They are thin-shanked, with an external diameter of 1.65 mm. (about the size of a 17-gauge intravenous needle), and have trocar tips which, when dulled after their initial use, are never resharpened. We believe that this protects the contiguous pelvic viscera, the large pelvic vessels and the ureters. The hub contains an eye through which a stainless steel leader is threaded, and these are held in place by a crushed lead shot. This prevents the needles from slipping up beyond the vaginal mucous membrane after their insertion.

The 3 mgm. needles are 60 mm. long with an active length of 45 mm. They are filtered with 0.5 mm. of platinum and contain .66 mgm/radium per cm. of active length. The 2 mgm. needles are 44 mm. long with an active length of 30 mm. They, too, are filtered with 0.5 mm. of platinum and also contain .66 mgm. of radium per cm. of active length.

We use also a central cervical applicator which is 52 mm. long with an active length of 40 mm. It is carried in a Monel metal sheath and is filtered with 0.5 mm. of platinum, and contains 20 mgm/radium.

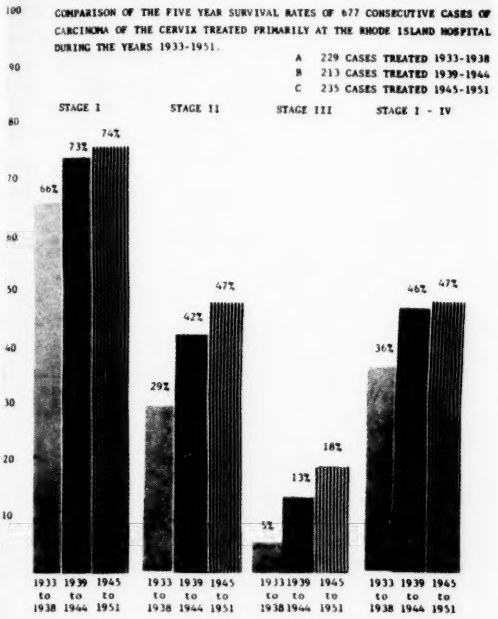
All of our cases are classified according to the League of Nations standards as modified in 1950. The classification is usually recorded by the first senior clinic man to examine the patient, and in cases of controversy, the lower staging is chosen. On occasion, patients are examined in the operating room; this is necessary usually because of tenderness, nulliparity and exogenous obesity.

The technique of insertion of the capsule and needles has been previously described by Dr. Pitts and Dr. Waterman, and our usual dosage varies between 6000 and 9000 mgm/hr. We treat the disease and not the pelvis as does Dr. Corscaden, and for this reason, since we have no radiation physicist, it is difficult to apply our insertion to standard isodose charts and report our figures in gamma roentgens. In 1942, Quimby and Nolan calculated isodose levels for one of our cases. The dose delivered to the central cervix was 15,000 r, to the medial parametrium 7,000-9,000 r, and to the lateral parametrium 4,000-6,000 r. Adequate dosage, then, was delivered to all save the lateral parametrium, and the pelvic wall or Tod's Point B would, by our methods, receive even less effect.

It is now fairly well acknowledged that deep X ray, even by conventional dosage, can destroy cancer in the pelvic lymph nodes and we use this additional method of treatment routinely. We mention the effectiveness of conventional X ray here because of the comparison of a small recent series of ours with Dr. Howard Taylor's in New York. In our series extra-peritoneal node dissections were done at the

FIGURE 1

Comparison of five-year survival rates of 677 consecutive cases of carcinoma of cervix treated at Rhode Island Hospital during years 1933-1951



time when interstitial radium was applied. Our positive node recovery was 28%. In Dr. Taylor's series, the node dissections were done following full radiation and his positive node incidence was only 2%.

We are still a radiation-minded clinic, but we are not unmindful of the benefits of surgery in the treatment of cervical cancer. We mention this particularly in consideration of our recent survival figures. Figure 1 was prepared by Dr. Sumner Raphael in his recent evaluation of our statistics. It records the cases treated from 1933-1951, broken down into six-year segments, for ease of reporting. It shows a consideration of salvage in LON, Stages I, II, III, and our composite series. We have no Stage IV cases living and available for five-year report. The improvement in over-all salvage from 1933-1938 to 1939-1944 is clearly shown. We are also proud of our recent five-year survival figures, but we are at the same time a little disappointed that the same increment of improvement was not seen. It appeared possible that we might be reaching an end-point in our radiological titration, at least with the methods currently at our disposal, namely, interstitial radiation and conventional 250 KV X ray. Supravoltage rotation therapy will soon be available to us, but since it is not available at the present time, we must look elsewhere for improvement. With this in mind, it was the decision of our Tumor Clinic, about five years ago, to embark on a program of surgery in support of radiation. This is not a new or original contribution with us; other and larger clinics are doing the same thing; Dr. Howard Taylor at the Presbyterian Hospital in New York, and Dr. Robert Kimbrough at the Graduate Hospital, the University of Pennsylvania, to mention just two.

This study, then, embraces an eight-year period from January, 1950, through December, 1957, during which time 371 new cases of cervical cancer were processed in our clinic; of this number 141, or 38%, received some type of surgery in the management of their disease. Figure 2 shows the five categories under consideration. 37% were non-invasive lesions, 17% were elective node dissections, 25% were radical hysterectomies, 3% pelvic exenterations, and 17% miscellaneous procedures. Figure 3 illustrates the fact that the main surgical attack on the invasive cancers was directed towards the more favorable cases, principally Stage I and Stage II. Also illustrated here is the fact that in 70% of the cases surgery was the primary consideration, and in the remaining 30% it was secondary to radiation.

FIGURE 2

Methods of treatment employed in 141 operatively selected cases

Recent use of surgery in support of radiation for cervical cancer 1950-1957

Total Cases 371 — 100%
Total Cases Operated 141 — 37.7%

Treatment	No. Cases	% Operated Cases
Ca.-in-situ	52	36.8%
Pelvic node dissection		
Transperitoneal	5	3.5%
Extraperitoneal	20	14.2%
Radical hysterectomy with node dissection	36	25.5%
Pelvic exenteration		
Total	3	2.1%
Posterior	1	.7%
Miscellaneous	24	17.0%
Total	141	100%

FIGURE 3

Clinical staging of cases selected for surgery
Recent use of surgery in support of radiation for cervical cancer

Stage	Primary	Secondary	Total
0	52	.....	52—36.9%
i	31	8	39—27.7%
ii	11	22	33—23.4%
iii	1	10	11— 7.8%
iv	1	5	6— 4.2%
Total	96	45	141— 100%

continued on next page

FIGURE 4
Carcinoma-in-situ, Rhode Island Hospital experience 1950-1957
Age Span 24-61 yrs.
Average Age 40.3 yrs.

Management	No.	Per Cent
Conization	4	7.7%
Cervicectomy	2	3.9%
Amputation of cervix	2	3.9%
Vaginal hysterectomy	4	7.7%
Extended abdominal hysterectomy	7	13.4%
Hysterectomy, routine	4	7.9%
Hysterectomy with unilateral salpingo-oophorectomy	9	17.3%
Hysterectomy with bilateral salpingo-oophorectomy	19	36.5%
Radical hysterectomy	1	1.9%
Total	52	100%

23 cases with residual ovarian function
Results: 51/52 survivors 3 mos.-8 yrs.
1 died, murder; no disease at autopsy

Fifty-two of these cases were non-invasive lesions (Figure 4) which were managed in a variety of ways. Only one of these patients escaped with an intact reproductive system, and only twenty-three have preserved ovarian function. Since our average age in this group is forty years, we believe that a higher percentage of patients should have their ovaries preserved. There was one death.

Our experience with the transperitoneal node dissection is limited (Figure 5). All of these patients were screened for more extensive surgery, because of the finding of pelvic disease, independent of and remote from, the cervical lesion. In all instances, the suspected area was benign, and a transperitoneal node dissection was done in conjunction with some other minor abdominal surgery.

FIGURE 5
Transperitoneal node dissections 1950-1957
Age Span 34-60 yrs.
Average Age 48.4 yrs.
All cases treated with radium 7224-9295 mgm/hrs.
***2 Cases received X ray following node surgery**
Follow-up 3-4.5 yrs.

Stage	Primary No.	Primary Survival	Secondary No.	Secondary Survival	Total No.	Total Survival
i	1	1	.....	.....	1	1—100%
ii	*2	1	*2	2	4	3— 75%
Total	3	2	2	2	5	4— 80%

All Cases Revealed Negative Nodes

1 primary case died of overwhelming sepsis; autopsy revealed uncontrolled disease in left parametrium

Three of the patients represented primary treatment, and the remaining two were secondary. One was a Stage I case, and the remaining four were Stage II. All showed negative nodes. There was one death. This occurred in a Stage II case who developed a severe pelvic abscess with overwhelming sepsis. X rays showed evidence of bone destruction; autopsy revealed a chain of uncontrolled disease in the left parametrium. One of these patients was very interesting. She had an advanced Stage II B lesion and received a large dose of radium and X ray. She developed rectal bleeding, tenesmus, and a pelvic mass. Operation revealed advanced radiation fibrosis and a transperitoneal node dissection was done in conjunction with a colostomy. After one year the colostomy was closed; the patient has remained asymptomatic and free of disease since that time.

Our preferred approach to the pelvic lymph nodes is by Nathanson's extraperitoneal operation (Figure 6). Twenty of our cases were managed in this way, 12 as primary treatment and eight secondary. There were nine Stage I cases, all with negative nodes, 10 Stage II cases, six of which showed positive nodes, and one Stage III case with positive nodes.

FIGURE 6
Extraperitoneal pelvic node dissections
Age Span 28-65 yrs.
Average Age 48.3 yrs.
All cases received radium 7392-9576 mgm/hrs.
***4 Cases received X ray following node surgery**
Follow-up 7-29 mos.

Stage	Primary No.	Primary Survival	Secondary No.	Secondary Survival	Total No.	Total Survival
i	7	7	2	2	9	9—100%
ii	*4	4	*6	4	10	8— 80%
iii	*1	1	0	0	1	1—100%
Total	12	12	8	6	20	18— 90%

Lymph Node Findings:
LON i (9) No Positive Nodes
LON ii (10) 6 With Positive Nodes
LON iii (1) Positive Nodes

There were two dramatic complications in this group, one, inadvertent division of the left external iliac artery. This was immediately repaired with an excellent functional result. The other patient developed a cold, pulseless, marbled right leg immediately after her operation. Re-exploration failed to reveal any inadvertent injury or ligation, but the right external iliac artery was pulseless. Periarterial sympathectomy, right lumbar sympathectomy and embolectomy were carried out and circulation was re-established. The lower leg, however, never recovered and amputation was necessary seven days later. This patient has subsequently died of her disease.

At the time of this report 18 of 20 patients, or 90%, are living. Two, however, have residual disease. It should be pointed out that these are not five-year survival figures.

Thirty-six, or 25%, of our cases were treated by radical hysterectomy and node dissection of the

Wertheim type (Figure 7). Twenty-three were primary procedures, and thirteen were secondary to radiation. Our decision to elect primary surgery in these twenty-three cases was for one of three reasons: (1) adenocarcinoma of cervix, (2) pregnancy, or (3) resident teaching. There were twenty-three Stage I cases; six with positive nodes, 10 Stage II cases, five of which showed positive nodes and three Stage III cases, two with positive nodes.

FIGURE 7
Radical hysterectomy and pelvic node dissection 1950-1957
Age Span 29-62 yrs.
Average Age 43 yrs.
Follow-up 2 mos.-8 yrs.

Stage	Primary No.	Primary Survival	Secondary No.	Secondary Survival	Total No.	Total Survival
i	20	19	3	2	23	21—91.3%
ii	3	3	7	4	10	7—70%
iii	.....	.....	3	1	3	1—33%
Total	23	22	13	7	36	29—80.6%

Lymph Node Findings:
LON i (23) 6 With Positive Nodes
LON ii (10) 5 With Positive Nodes
LON iii (3) 2 With Positive Nodes

There have been a few complications in this group. One inadvertent ligation of the right external and common iliac artery. De-ligation was carried out within four hours, with a good circulatory result. This patient has since died. She showed an advanced Stage II disease, with extensive node and parametrial involvement. Her primary cell type was adenocarcinoma.

There have been three vesico-vaginal fistulas, two of which were caused by traumatic sexual intercourse within one week of discharge from the hospital. One of these fistulas healed primarily, one was closed surgically, and the third is waiting for an attempted repair.

There were seven deaths in this group. Two in Stage I, three in Stage II, and two in Stage III; all had positive nodes, and all died of disease.

Our salvage, at the present time, in this group is 81%; once again these are not five-year survival figures.

Through December, 1957, we had done only four pelvic exenterations (Figure 8). Three were total, and one a posterior exenteration with preservation of the urinary tract. The one posterior exenteration should perhaps, not be included. Her primary disease was in the rectum, but she did have a metastatic involvement of the cervix and vagina. She is living and well, free of disease, two years since operation.

All were Stage IV disease, all were treated previously by X ray and radium. In two of the total exenterations the ureters were managed by isoperistaltic ileal pouches, and in the third by ureterocolostomy. The last patient died on her forty-third hospital day, with intestinal obstruction, peritonitis and uretero-vaginal fistula. The other two patients have also died; one eleven months postoperatively, of disease, and the second of aspiration following tube feeding. At autopsy she was free of disease.

In the exenteration group, then, we report one patient out of four living and well. Again, not a five-year survival figure.

FIGURE 8
Pelvic exenteration 1950-1957
Age Span 42-70 yrs.
Average Age 53 yrs.
Follow-up 2 yrs.

Stage	Primary No.	Primary Survival	Secondary No.	Secondary Survival	Total No.	Total Survival
iv	.....	.....	4	1*	4	1—25%

Lymph Node Findings:
LON iv (4) All With Positive Nodes
*Posterior exenteration living and well, free of disease, 2 yrs.

The remaining twenty-four patients are bracketed in a so-called miscellaneous group (Figure 9). A variety of operations is represented here, including pneumonectomy, vulvectomy, colostomy, colon resection, etc.

Six of these procedures were primary, four abdominal hysterectomies, and two vaginal hysterectomies with four survivals. The remaining eighteen cases were subjected to surgery as a secondary consideration with an additional five survivors.

At the time of this report, then, nine of these 24 patients, or 37.5%, are alive; not all of them, however, are free of disease.

FIGURE 9
Miscellaneous procedures
Age Span 37-83 yrs.
Average Age 54.1 yrs.
Follow-up 2 mos.-8 yrs.

Stage	Primary No.	Primary Survival	Secondary No.	Secondary Survival	Total No.	Total Survival
i	3	2	3	2	6	4—66.6%
ii	2	2	7	1	9	3—33.3%
iii	.....	.....	7	2	7	2—28.5%
iv	1	0	1	.....	2	0
Total	6	4	18	5	24	9—37.5%

Figure 10 attempts to correlate the survivals in these various categories. The survival rate in primary treated cases is 93.7%, which is adjusted to 91% to allow for exclusion of the non-invasive lesions. Our secondary survival rate is 46.6%. Considering the primary and secondary cases together, there are 61 survivors of 89 cases, if we

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FIGURE 10
Recent use of surgery in support of radiation for cervical cancer 1950-1957
Primary vs. secondary therapy survival total cases

Method of Treatment		Primary	Secondary
CA.-in-situ		51/52	.....
Transperitoneal nodes		2/3	2/2
Extraperitoneal nodes		12/12	6/8
Radical hysterectomy		22/23	7/13
Exenteration		.....	1/4
Miscellaneous		4/6	5/18
Total	All	91/96—93.7%	21/45—46.6%
	Invasive	40/44—91%	

again exclude the non-invasive lesions; this gives us a figure of 70%—not five-year figures.

In any study carried out in our clinic, one fact is always obvious, that, regardless of other variables, the clinical stage of the disease is the main determinant as regards salvage. Figure 11 illustrates this very well.

FIGURE 11
Recent Use of Surgery in Support of Radiation for Cervical Cancer 1950-1957
Total Operated Cases 141
Survival according to stage

Stage	No.	Survival
0	52	51—98.1%
i	39	35—90.0%
ii	33	21—63.6%
iii	11	4—36.4%
iv	6	1—16.6%
Total	141	112—79.3%

SUMMARY

In summary, this has been an evaluation of 141 cases of cancer of the cervix which were selectively screened for surgery from 1950-1957. This represents 38% of the total new cases of cervical cancer seen during this period of time. Fifty-two cases were non-invasive lesions, all treated surgically with a 98% survival rate. There were 25 cases of lymph node dissection with an 88% survival rate, 36 radical hysterectomies with 82% survivals and four pelvic exenterations with a 25% survival rate. The remaining 24 cases represented miscellaneous procedures with a 37% survival rate. Our over-all survival rate, exclusive of the non-invasive lesions, is 70%. It must be emphasized again that these are not five-year survival figures.

Conclusion

Our final conclusion is, that our survivals are directly proportional to the stage of the disease when the patient is first seen.

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society

106 Francis Street, Providence, Rhode Island

WHOSE HOOP IS BEING TWIRLED?

(The editors of this Journal have published two editorials relating to the hospital-surgical provisions of the proposed social security amendments submitted to the Congressional House of Representatives in 1957 by Congressman Aime J. Forand of Rhode Island. Because proponents of compulsory federal legislation express views with which we are in disagreement, the editors offer the information below for the benefit of readers of this Journal.)

* * *

The medical profession of Rhode Island does not oppose the Social Security Act *per se*. It does have misgivings about its operation, and it does criticize the continuous efforts of certain political groups to change the concept of the program into one of state socialism.

The original act, passed 23 years ago, promised 33 million people permanent insurance coverage after five years of payments, but within four years the lawmakers decided everyone should pay for ten years instead of five.

The original act guaranteed the taxpayer that he or his estate would get his money back with interest if he did not use it up in annuities. This promise was kept to a half million beneficiaries, and then arbitrarily canceled for everyone else.

Both the base taxable amount and the rate have been altered more on political expediency rather than on the basis of the realities of the situation. Congressman Mills' statements noted below illustrate this excellently. Any time the fund ever gets into trouble—as it is right now—Congress can rehabilitate it by increasing taxes. Some politicians and some newspaper editors still call this kind of a system *insurance*, yet they would never allow any insurance company in the nation to operate on such a basis. Our local largest newspaper speaks of the record of social security for *fiscal stability*. Any government program, federal or state, can continue its financial stability when it merely has to reach into the taxpayer's pocket to make up losses incurred by its overspending.

What Is the Financial Status of the Social Security System?

Read what Congressman Mills, Arkansas democrat, and chairman of the committee that considered the amendments to the Social Security system, told the members of the House of Representatives in Congress when he reported to them last July 31:

Let me digress a moment here, Mr. Chairman, to explain that under legislation enacted by the Congress in 1956 an Advisory Council on Social Security Financing was set up and is now studying and preparing recommendations on the financing of the old-age and survivors' insurance and the disability insurance program. The council's report is not due until the end of this year. The Committee on Ways and Means looks forward to receiving this report and expects that the report will be helpful in its evaluation of cost-estimating methods, procedures, and

continued on next page

policies connected with the investment of the assets of the old-age, survivors' and disability insurance trust funds, and the principles underlying the financing of the program. In our committee's opinion, however, the degree to which the old-age and survivors' insurance trust fund is out of balance over the long range and the excess of outgo over income during the next seven years are matters that demand immediate action. We believe that the financial soundness of the social-security program is too vitally important to the American people for us to delay until another year the action that is clearly needed to reduce the present actuarial insufficiency.

Mr. Chairman, we were concerned in the committee with information that came to us to the effect that if we did not collect any more money for the system and did not permit anyone in addition to those presently drawing benefits to be added to the rolls, and only paid benefits to those presently drawing in accordance with the provisions of existing law, that the fund, even though it is now 22 billion dollars, would lack 65 billion dollars of meeting these present obligations to those now drawing benefits.

In addition, Mr. Chairman, we were told that under the provisions of existing law, despite a scheduled increase in taxes in 1960 and again in 1965, for a period of the next seven years, including this present calendar year, we would pay out of the social security trust fund more in each year than we would take into the fund—to the total of some 4 billion dollars more paid out than taken in in these seven years. Up to 1958, Mr. Chairman, as all members know, we have succeeded in taking into the social security trust fund more each year than we have paid out. We were also reminded, Mr. Chairman, of the fact that over the course of several years prior to 1950 we had not permitted the tax-rate increases that had originally been levied for this purpose to go into effect and to rise in accordance with the original legislation. We were told that had we permitted those original tax increases to go into effect the combined total payroll tax for this purpose today would be 6 per cent tax instead of the present rate of 4½ per cent, and that we would not be in the position we are in under existing law of paying out of the fund more than we take in for an immediate period of seven years.

* * *

When we first enacted this program, Mr. Chairman, it was anticipated it would be completely in balance and there would be some on the plus side; but in view of all I have discussed, the failure on the part of the Congress earlier to permit the tax rates to rise in accordance with the original intention, irrespective of the fact that from time to time we have increased the benefits, we find ourselves now in the position where if we do not take action we can look forward to the time when we will not take into the fund the amounts of money that will be required to pay the benefits that are presently contemplated under existing law. Under these circumstances, unless something is done, there will be no other recourse than to dip into the general funds of the treasury for those amounts.

Think of what that may mean. There are only 12 million today who are drawing benefits, but there are 75 million additional people who are now covered by social security who at some time or other in the future will be eligible for these benefits.

* * *

When we questioned the operation of the Dependents' Medical Care Program a year ago, we drew criticism that was unwarranted. Yet within the year the same type of actuarial thinking that appears to permeate many of our federal tax programs proved far from sound, and the Medicare budget of seventy million dollars was overspent by twenty million, even with strict supervision by the authorities representing the armed services. Congress cut back the Medicare appropriation, and when it finally permitted it at the 70 million-dollar figure for this year it imposed strict regulations to reduce the use of civilian hospitals and physicians, and to put the beneficiaries of the program into governmental facilities for their care. The right of free choice was indeed short-lived. And it could have as brief an existence under any other tax-controlled medical care program, administered under social security or any other federal agency.

But, Say the Proponents of the Social Security Health Proposal, Federal Control of Medicine Is Not Permitted

Such is the cry of the proponents of the legislation, and some newspaper editors have been quick to uphold the contention that the Forand bill, for example, specifically provides that there shall be no government control of the practice of medicine. Doesn't it say so in the law? Section 226(d)(8) states:

> *"Nothing in such agreements or in this act shall be construed to give the Secretary supervision or control over the practice of medicine or the manner in which medical services are supervised."*

But what is the practice of medicine?

Does it not include fair compensation for services rendered? Does any man practice his profession, or engage in his work, without consideration of payment for his services as he shall deem their value? When a third party determines the compensation, on its terms, does it not interfere in the practice of that profession?

After including the generalization noted above in the legislation, a generalization that infers no interference whatever in the over-all practice of medicine, the proposed law includes the following interesting provisions which could be greatly expanded by administrative regulation, just as was done with the Medicare law:

> "SEC. 226(a)(5) *The provisions of Section 205 relating to the making and review of determinations shall be applicable to determinations as to whether the costs of hospital, nursing home, and surgical services furnished an individual may be paid for out of the Federal Old Age and Survivors' Insurance Trust Fund under this subsection, and the amount of such payments.*"

* * *

> "SEC. 226(d)(7) *The Secretary shall enter into agreements with qualified providers of surgical services as defined in paragraph(2) of*

subsection (c). Such agreements shall stipulate that the rate of payment agreed on shall constitute full payment for these services. Such agreements may be made with any qualified individual, or with any association or organization authorized by the surgeons, dentists, or physicians to act in their behalf."

* * *

"SEC. 226(c)(2) *Any individual referred to in paragraph (1) and (2) of subsection (a) may, with respect to the surgical services for which payment is provided by this section, freely select the surgeon of his choice, PROVIDED that the surgeon is certified by the American College of Surgeons except that such certification shall not be required in cases of emergency where the life of the patient would be endangered by any delay, or in such other cases where such certification is not practicable, and except that, in the case of oral surgery, such individual may select a duly licensed dentist."*

* * *

"SEC. 226(c)(3) *Regulations under this section shall provide for payments (in such amounts and upon such conditions as may be prescribed in such regulations) to . . . (B) physicians for surgical services rendered by physicians not certified by the American Board of Surgery or not members of the American College of Surgery." (Underscoring added.)*

* * *

"SEC. 226(d)(9) *Except to the extent the Secretary has made provision pursuant to subsection (h) for the making of payments to hospitals and nursing homes by a private nonprofit organization or for the making of payments to physicians, dentists, and surgeons by their designated representatives, he shall from time to time determine the amount to be paid such provider of service under an agreement with respect to services furnished. . . ." (Underscoring added.)*

* * *

Add to these stated provisions the many ramifications of the law possible by administrative regulation, such as were generated by the Department of Defense in amplifying the law providing benefits for the dependents of armed services personnel, and the supervision and indirect control of the practice of medicine is an achieved result.

What's Wrong, Then, With the Voluntary System?

Actually, there is nothing wrong with the extraordinary development of voluntary health insurance in this country in the past decade. As a matter of fact it is one of the brightest achievements in a society that is saturated with false senses of security by political and social planners.

As we reported previously, our voluntary Rhode Island Blue Cross and Physicians Service plans have the highest enrollment in the nation, and in that enrollment are approximately 66,000 of the reported 80,000 residents over the age 65. While admitting that record is outstanding, one of our most voluble critics emits a loud cry of "what about the 14,000 people who are not protected?"

For the record, let it be stated that our latest report showed 7,200 of these people to be getting not only hospital and surgical care, but medical care also, and to whatever extent needed, through the state public assistance program which Rhode Island doctors greatly subsidize. An additional 1,500 are housed in state institutions, other than penal, and are getting complete medical care. We would like to believe, also, that there are still some residents who have purchased adequate insurance coverages or have sufficient income, after a lifetime of work, to insure them of the costs of any necessary medical attention they may need in their old age.

Our critic is aghast that we suggest that any segment of the population may have recourse to charitable organizations for such aid. Instead, he upholds Mr. Forand's proposal whereby everyone would surrender his right to provide for his needs, public assistance would be scrapped, and everyone would be happy under a compulsory taxation program, with the federal government calling the tune.

An enforced savings plan for a segment of the population that cannot, or will not make provisions for its needs, whether for old age or in general, may be justifiable by some standards, in spite of the abuses and shortcomings it presents. But to insist that the remainder of the population be included by compulsion in the same scheme is indefensible.

ACCIDENTS IN THE HOME

The number of injuries and deaths from accidents in the home is increasing, according to the Home Accident Survey made by the Rhode Island Department of Health in co-operation with the Hospital Association of Rhode Island. The survey indicates that many, if not most, of these accidents are preventable. During a twelve-month period, nearly 14,000 home accident cases were seen in the accident rooms of hospitals throughout our state. In the year 1956, 128 people died from accidents occurring in the home; 78% of these deaths were due to falls. An analysis of deaths in Rhode Island shows that accidents, exclusive of those due to motor vehicles, are the leading cause of death in the age group 1 to 14 years and in the age group 20

concluded on next page

CATHOLIC CHARITIES NIX FEDERAL HANDOUTS

Apparently concerned over the Santa Claus antics of Congress in the field of Social Security, Msgr. John O'Grady, secretary of the National Conference of Catholic Charities, said the over-all relief programs "represent the welfare state in its most complete form."

The monsignor added that "at this time, we are not sympathetic about having the Federal Government enter the field of hospital and medical group insurance. We believe that it brings the Federal Government too close to the problems of family life. It is an entire departure from the objectives of a social insurance program."

. . . *Newsletter*, California Medical Association

PART-TIME CONTRACT SURGEON WANTED

1. Headquarters, 4th Msl Bn (NIKE AJAX) 68th Arty, Coventry, Rhode Island, is interested in obtaining a part-time contract surgeon to service military personnel and their dependents assigned to Btry C and Btry D of this battalion located at Slatersville and Foster Center, Rhode Island, respectively.

2. To be eligible for employment as a contract surgeon, the candidate must be a graduate of a medical school legally authorized to confer the degree of Doctor of Medicine. The candidate must also be a licensed practitioner in good standing and must possess acceptable moral, professional and physical qualifications.

3. Persons interested and wanting further information as to the duties of the position may obtain same by contacting one of the following persons:

LT. COL. LON R. DICKSON
Commanding Officer
4th Msl Bn (NIKE AJAX) 68th Arty
Coventry, Rhode Island
Telephone: EXpress 7-3674

MAJOR EDGAR A. TUCKER, MC
Post Surgeon
U.S. Army Dispensary, Boston Army Base
Boston 10, Massachusetts
Telephone: LIberty 2-6000, Extension 123

2/LT. EDWARD N. CONROY
Medical Service Officer
4th Msl Bn (NIKE AJAX) 68th Arty
Coventry, Rhode Island
Telephone: EXpress 7-3672

to 29.

From February 1, 1956 to January 31, 1957, 13,277 persons were injured; for these the most dangerous locale was the yard (3,534), the kitchen (3,049), and the bedroom (1,155), followed by the living room (905), the inside stairs (795), the bathroom (504), and the cellar (475).

Men were injured more often than women; there were 7,235 men and 6,042 women. It is of interest to note that children were injured more frequently than were adults. From the first to the fifteenth year there were 7,575; from the fifteenth to the fortieth, 2,825.

Graded as to their severity, the major accidents occurred in the kitchen (242), the yard (234), and the bedroom (153).

When one reflects that this Home Accident Survey records only those cases which were cared for in the inpatient or outpatient departments of hospitals and does not record those many other cases which did not seek hospital care, it is clear that home safety is an important matter of public health. Everyone knows that the toll of the road is serious, but perhaps not many of us are as acutely aware as we should be that the toll of the home is no less serious.

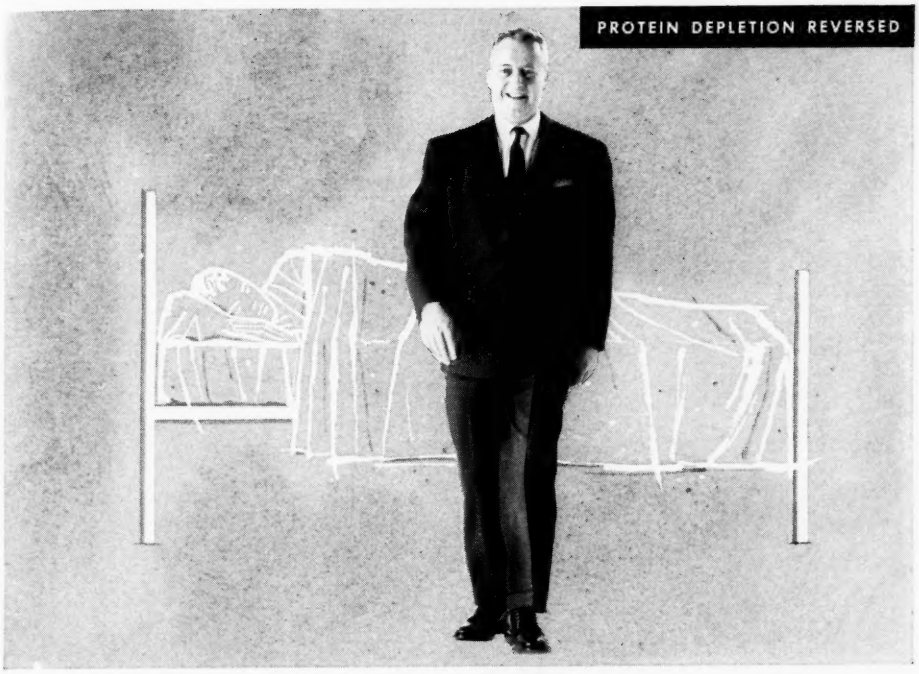
ANNUAL PHARMACY CLINIC

The announcement of the first of an annual series of pharmacy clinics to be conducted by University of Rhode Island faculty and outstanding guest speakers warrants attention equally by physicians as by pharmacists.

For many centuries medicine and pharmacy were inseparable, and it was not until the German Emperor Frederick II, in 1242, decreed independent regulation of the practice of pharmacy in the kingdom of the two Sicilies that the two distinct branches of the healing arts developed as we know them today.

The two-day series of lectures to be held at Kingston on November 18 and 19 will aim to provide the physician, the pharmacist, the dentist and the veterinarian with an opportunity to learn of recent developments in pharmacotherapy, the latest regulations governing the use, handling, prescribing and dispensing drugs, and the current economic issues affecting the professions devoted to the healing art.

The program of lectures is published on page 582 of this issue of the Journal. The University of Rhode Island, through its College of Pharmacy, extends an invitation to every member of the Rhode Island Medical Society to attend the sessions as its guest. We hope the invitation will be accepted by many.



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- **The patient feels better**
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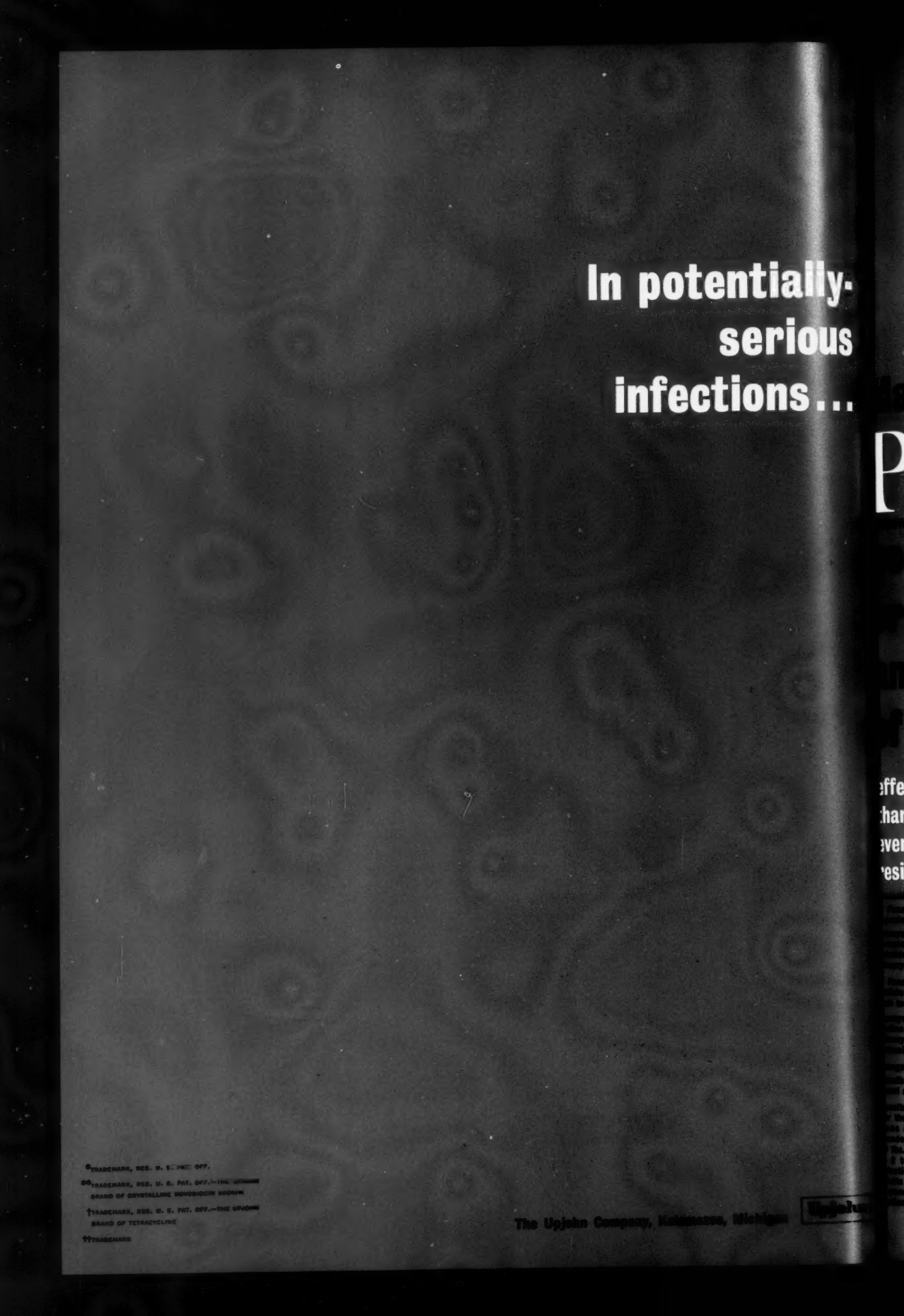
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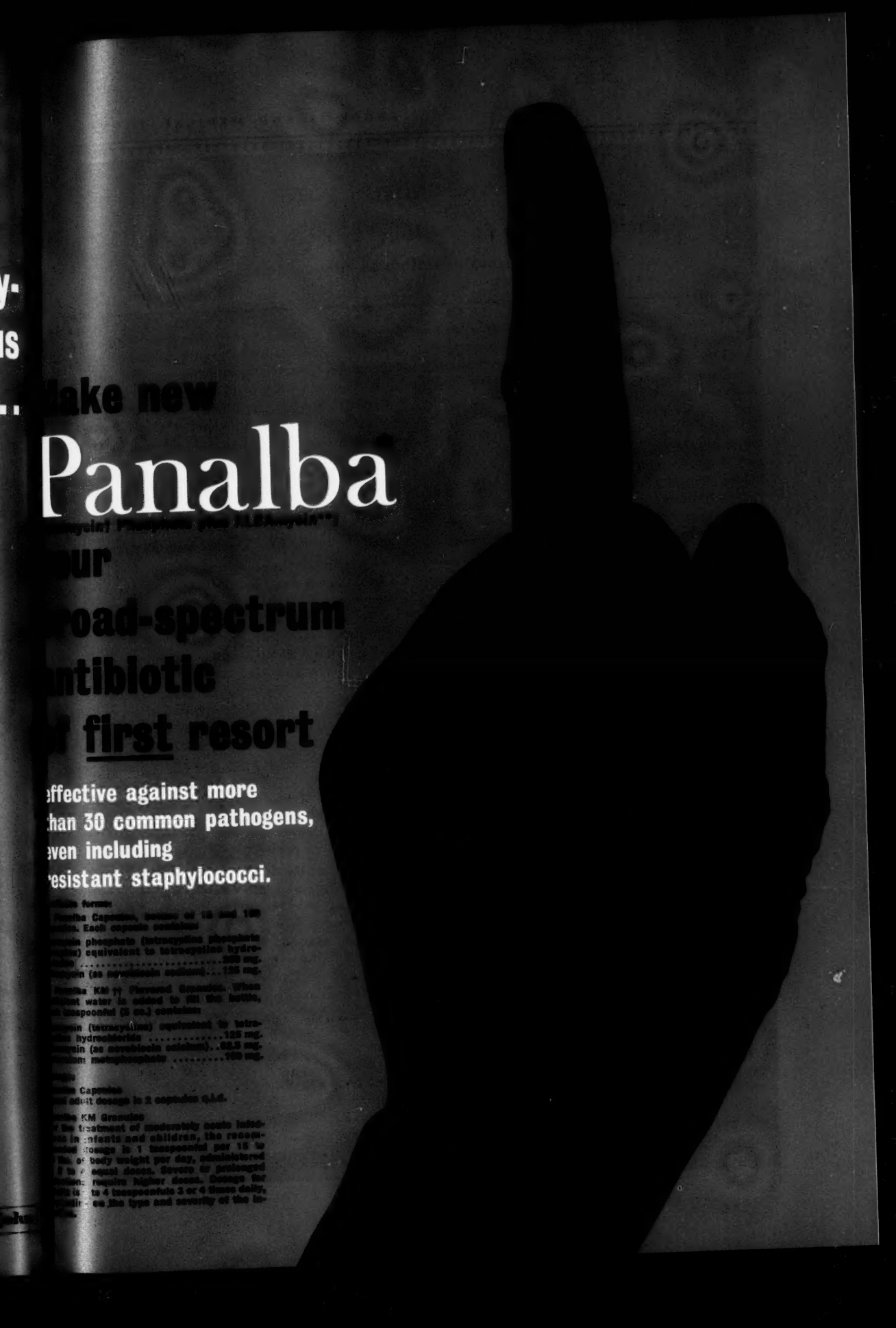
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THE WASHINGTON SCENE

Quarterly Legislative Review Issued by the Washington Office of the American Medical Association

THE SECOND SESSION of the 85th Congress, beset with space age and other problems and operating in the charged atmosphere of an election year, found time to take up an unusual number of bills of interest to medicine. It passed more than a dozen. Just as notable were two bills that did not pass. While the Forand bill for a hospitalization program under social security failed to clear the House Ways and Means Committee, the committee did order the Department of Health, Education, and Welfare to make a thorough study of the problem of financing medical care of the aged, with emphasis on use of social security. Because the report is due by next February 1, the basic issue is almost certain to come to the front again early in the new Congress. Another major issue left hanging was that of tax-deferment on annuities for the self-employed—the Keogh bill. It went through the House by an overwhelming vote and won the support of 32 Senators, two factors that suggest it may be enacted next year.

In the following pages we review briefly the provisions of all major health bills enacted in both sessions of the 85th Congress, and outline the prospects for the more important measures that were left by the wayside.

* * *

Medicare Appropriations
(Public Law 85-724, Aug. 22)

Congress took a long look at the medicare program, now nearing its second anniversary, and decided that the civilian phase of the program had to be curtailed in favor of greater use of military facilities. The House first trimmed $10.2 million from an admittedly slim budget of $70.2 million, and then wrote into the Defense Department appropriation a section that would have prevented the services from asking for any supplemental appropriation for the entire fiscal year or using other funds. When it reached the Senate, Medicare and Defense officials joined with the American Medical Association and others in a plea for restoration of funds and elimination of the destructive section. This was accomplished through an amendment sponsored by Senator Knowland (R., Calif.). In the ensuing conference, language was written in a report which, while not having the full force of law, nonetheless directed the military to start cutting back on some aspects of civilian medicare. To this end, the Office for Dependents Medical Care announced new restrictions effective this fall. They are aimed at higher military facilities utilization, such as requiring dependents living with sponsors to use military resources unless they are not available.

Social Security Amendments
(Public Law 85-840, Aug. 28)

As it has done every election year since 1950, Congress again amended the Social Security Act. It increased Old Age, Survivors and Disability Insurance benefits by 7%, in response to demands that benefits keep pace with the cost of living. It provided an additional $197 million for public assistance recipients, and gave states greater flexibility in use of federal funds for financing the medical care of the aged, blind, the disabled and dependent children. To finance the liberalizations, the law increases the taxable base from $4200 to $4800 of gross employment earnings and raises the tax in 1959 from 2¼% to 2½% for the employer and employee, and from 3⅜% to 3¾% for the self-employed. Additional increases are scheduled for 1960, 1963, 1966 and 1969. By 1969, the self-employed will be paying 6¾% of earnings.

Congress left the door ajar for consideration by the next Congress of bills using the social security system to provide hospital and medical care for OASDI beneficiaries. An articulate minority wanted this enacted this year via the proposal of Rep. Aime Forand (D., R.I.), but Congress decided against it. However, the House Ways and Means Committee directed the administration to make a study and report by next February on the various possibilities for financing medical care for the aged, with particular emphasis on the possible practicability of increasing OASDI taxes and using the money to purchase health insurance on retirement. The A.M.A. took a strong stand against using the social security system to provide such care, viewing it as a beginning of national compulsory health insurance.

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THE WASHINGTON SCENE

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White House Conference on Aging
(Signed Sept. 2, Awaiting P.L. No.)

The President is instructed to call a White House Conference on Aging in January, 1961, by a measure passed late in the session. This national meeting will bring together federal, state and local leaders working in the field of aging. Their objective: to arrive at facts and recommendations on the utilization of skills, experiences and energies, and the improvement of the conditions of older people. A final report would be submitted to the President within 90 days after the conference. A series of state-organized meetings would precede the 1961 conference. To help the states finance these meetings, the law provides up to $15,000 a state with a minimum of $5,000. These figures, reduced from the original $50,000 per state, were used with the anticipation that states would also participate substantially in the financing. The A.M.A. gave this legislation its full support; author of the bill was Rep. John Fogarty (D., R.I.).

Chemical Additives in Food
(Awaiting Presidential Signature)

In an eleventh hour action, the Senate passed a House-approved bill on the last day of the session which prohibits use of chemical additives in foods until their pre-testing has been approved by the Food and Drug Administration. Elaborate provisions are made for appeals to federal decisions.

Health Appropriations
(Public Law 85-580, Aug. 1)

In response to appeals from a number of sources, the 85th Congress set a new high in money voted for the Department of Health, Education, and Welfare, particularly for the U.S. Public Health Service. The latter now is spending at the rate of close to three quarters of a billion dollars a year. Last year P.H.S. received from Congress approximately $562 million; this year's total is $745,747,000. Members of Congress find it difficult to vote against more funds for medical research and a myriad of other health programs, once health-oriented House and Senate committees have agreed on certain figures for the ensuing year. Research money for the seven institutes was increased nearly 40% over last year, while the Hill-Burton hospital construction program received a boost of close to 55%. If one is to judge from a recent study group of H.E.W., the peak of spending in the health field hasn't yet been reached. Congress also voted $6.9 million for the long-sought new quarters for the National Library of Medicine.

Hill-Burton Amendments
(Public Law 85-589, Aug. 1 and Public Law 85-664, Aug. 14)

Because a full year's notice is deemed necessary in future planning, Congress voted a five-year extension of the Hill-Burton hospital construction program. The act otherwise would expire next June. In a separate action, Congress amended the act to permit for the first time Hill-Burton loans at the same rate of interest the government pays for its own borrowing. Under the loan act, an applicant would have to comply with all H-B regulations, the same as regular H-B applicants. The extension bill is Public Law 85-664, and the loan act, Public Law 85-589. The A.M.A. testified in support of the Hill-Burton extension.

Defense Reorganization
(Public Law 85-599, Aug. 6)

At the prodding of the House Armed Services Committee, the Defense Department is finally reorganizing. The number of Assistant Secretaries of Defense, which Congress felt had grown too large, was trimmed back by one. The affected post in all likelihood will be that of Assistant Secretary for Health and Medical Affairs, which would be downgraded to that of special assistant. The A.M.A. fought hard to have the act make clear that this post would be saved, and it continues hopeful that something can be worked out before the act goes into effect in January.

Public Health School Grants
(Public Law 85-544, July 22)

Eleven schools of public health were promised a total of $1 million annually in federal grants to assist them in professional training, specialized consultative services and technical assistance with the states. The final act was simply an authorization. Efforts were made late in the session by the Senate to add $1 million to a supplemental appropriation for a number of agencies. This item was knocked out in conference, which means that funds will not be available until the next Congress acts.

Civil Defense Grants
(Public Law 85-606, Aug. 8)

To bolster sagging state civil defense programs, Congress voted grants to the states for purchase of radiological instruments, personal equipment for state and local civil defense workers and for administrative and personnel expenses. Amounts for the first category would not exceed $35 million; for the second category, not more than $2 million, and for the third, not over $25 million.

Military and VA Pay Schedules
(Public Law 85-422, May 20, and Public Law 85-462, June 20)

General pay raises for the military (P.L. 85-422) included the same increases for physicians in the services. The law also retained the incentive pay schedule for doctors in uniform which has been in

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Comments by investigators on

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—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL of the American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL of the American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL of the American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

THE WASHINGTON SCENE

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effect since 1947. Congress, in a separate act (P.L. 85-462), also approved salary increases for physicians in the Veterans Administration. It voted down a provision that would have given VA optometrists the same professional status as physicians and dentists.

Union-Management Health and Welfare Plans
(Public Law 85-836, Aug. 28)

To correct abuses in health and welfare plans, Congress after considerable debate voted a measure requiring both labor and management health and welfare plans to make annual financial reports to the Secretary of Labor. It exempts plans with fewer than 25 members. Fines as high as $10,000 or five years imprisonment are provided for falsification of reports.

Research Facilities Extension
(Public Law 85-777, Aug. 27)

Two years ago Congress voted a new program of grants to help medical schools and similar facilities doing research in various crippling and killing diseases to construct laboratories and similar buildings or to remodel existing structures. The program was to run for three years, with an annual appropriation of $30 million. With a backlog of applications, the administration sought an extension for another three years. It also asked for a clarification of "multi-purpose" facilities. In the process, the bill was amended in committee so that money available would have been available for both research and teaching facilities. This back-door approach to medical school aid later was dropped by the committee, because it was felt that it would jeopardize passage of the simple extension.

Doctor Draft Extension
(Public Law 85-62, June 27, 1957)

Under this act passed in the first session, selective service has authority until July 1, 1959, to call certain physicians up to age 35 for military service. Only those doctors with obligations under the regular draft and who have been deferred for any reason may be called. Although the military has been getting enough doctors through new graduates and volunteers, it expects to ask for another extension next year.

Jenkins-Keogh Tax Deferral
(Died in Senate Finance Committee)

The drive to give the self-employed equal treatment with the employed in setting aside tax-deferred sums for retirement plans moved closer than ever to enactment. A bill passed the House late in July with only a smattering of opposition. But it died in the Senate Finance Committee: a major factor was Treasury Department insistence it would result in a large tax revenue loss. A.M.A., in concert with the American Thrift Assembly, pressed hard for enactment. New efforts to get the measure passed in the 86th Congress are being planned.

Community Facilities Loans
(Killed in House)

A bill that started out as an anti-recession measure lost steam as it progressed in Congress. It provided for low-interest loans to states and communities for a wide range of public works, including construction of community hospitals. The measure was voted down in the House after it had passed the Senate.

Medical School Construction Aid
(Died with the Congress)

Bills to authorize one-time grants for new and existing medical schools to build classrooms were pending in both House and Senate at adjournment. Extensive hearings were held by the House Interstate health subcommittee. No bill was reported to the floor because of (1) concern over the segregation issue, (2) a question of whether the states have exhausted all resources, and (3) a reluctance of some committee members to spend the money now. The A.M.A. supported one-time grants in its testimony.

Civil Aviation Medicine
(Died with the Congress)

Efforts to establish a Civil Air Surgeon with broad authority in civilian air safety failed to pass. But with creation of the Federal Aviation Agency, administration assurances have been given that the needs of aviation medicine will be considered in setting up the new agency. The A.M.A. was a strong supporter of the idea of a Civil Air Surgeon.

Veterans Hospitalization
(Died with the Congress)

Late in the session as a windup to lengthy hearings on veterans entitlement to VA hospitalization, the House Veterans Affairs Committee reported out an omnibus hospitalization bill. The measure had as its major objective the opening of some 5,000 additional beds which the committee maintains the Budget Bureau is holding back on. It was reported too late for final action. The A.M.A. testified in favor of a clear spelling out by Congress of veterans entitlement to federal care.

THROUGH . . .  *the Microscope*

Hill-Burton Act Continues On and On

Ten years ago the Congress passed the Hill-Burton act to provide matching funds with the states to aid in hospital construction. At the time of its passage the measure was characterized as an emergency provision that presumably would be terminated within two or three years. Such was not to be, however.

As of June 30 last year a total of 3,515 construction projects had been approved of which 2,346 were completed and in operation; 953 were under construction and 215 were in pre-construction stages. All in all these projects aimed to provide the 152,593 hospital beds and 888 public health and other medical facilities. Two thirds of the approved projects were general hospitals, 3 per cent mental hospitals, 2 per cent tuberculosis hospitals, 3 per cent chronic disease facilities, 17 per cent public health centers, and 9 per cent other related facilities. The appropriation to continue the work in 1958 was $121,200,000.

As of this past July, Rhode Island had listed thirteen projects approved, but not yet under construction at a total cost of $19,730,005 which included $3,273,202 federal contribution, and designed to supply 536 additional beds. Under construction were nine projects at a total cost of $10,565,522 including federal contribution of $1,582,260, and designed to supply 143 beds.

Canadians Curtail TB X-ray Tests

The NEW YORK TIMES reported recently that the National Sanitarium Association is abandoning all X-ray tests for tuberculosis for Canadians under forty years of age. The possible radiation hazards, particularly to the reproductive organs, contributed to the decision, the newspaper reported. The Ontario Department of Health was also reported to have partly switched to a tuberculin skin test for this age group and hopes to make the change province-wide soon.

Health and the Changing American Family

Improved health standards have been a major stabilizing influence on marriage and the family in recent years, according to Health Information Foundation. Because of declining death rates, the average parent today has a much better chance of living to see his children grow up; fewer children die; orphanhood has largely disappeared as a social problem. The number of orphans has dropped from 6.4 million in 1920 to 2.7 million in 1958. Yet the child population has risen from 39 to 60 million in that time. A typical child born today has 25 chances in 1,000 of losing his mother by death before he reaches 18, and 57 chances in 1,000 of losing his father. Fewer than one out of every thousand children in the country nowadays has lost both parents.

Chemical Test for Intoxication

The State of New York amended its implied consent law last February to be effective in July, 1958, whereby a physician shall not be sued for drawing blood for chemical tests when done at the request of a police officer. Under the law a suit may be maintained against the state or its subdivision depending on what police department is involved. The state or subdivision may in turn sue the physician for the amounts recovered by reason of gross negligence or bad faith on the part of such physician.

Still Is "Stilled"

Until last summer the constitution of the American Osteopathic Association included a provision that "the evolution of the osteopathic principles shall be an ever-growing tribute to Andrew Taylor Still, whose original researches made possible osteopathy as a science."

At a meeting of the House of Delegates in Washington in July all reference to Still was deleted from the constitution and the objects of the Association were simply stated to be "to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges."

Physician-Pharmacist Relations Surveyed

A survey of medical-pharmaceutical relations

concluded on page 572

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1. Highest tetracycline serum levels
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3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

4. More rapid clinical response
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THROUGH THE MICROSCOPE

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reported recently in the JOURNAL OF THE AMERICAN PHARMACEUTICAL ASSOCIATION cited the following as improvements most needed between the two professions:

1. Physicians should write more complete prescriptions, especially regarding refill information.
2. Physicians should be advised of the legal restrictions on drug sales.
3. Pharmacists need to eliminate unethical and illegal dispensing practices, and physicians should strive for fair sample distribution.
4. Physicians and pharmacists should work together to supply appropriate medical information to the public so that undesirable situations do not occur.
5. Pharmacists need to work out a convenient emergency service program to serve the needs of their community.

Rhode Island Excels in Vocational Rehabilitation

Federal statistics recently released show that Rhode Island ranks ninth nationally in the number of disabled persons rehabilitated per 100,000 population. The total number of rehabilitations in the state during the fiscal year ending last June reached an all-time high of 572. According to Miss Mary E. Switzer, director of the federal office of vocational rehabilitation, 74,320 of the nation's disabled were rehabilitated during the past year.

Basic Needs for Older Persons Listed

A plan for *positive health* was suggested to physicians attending a national conference called by the A.M.A.'s Committee on Aging in Chicago in September when Dr. Edward L. Bortz of Philadelphia cited ten basic needs as follows:

A balanced diet including more protein, vitamins, and fluids; less fats and calories.
Regular elimination of waste products.
Adequate rest of both mind and body.
Pursuit of interesting and specific recreational activities.
A sense of humor, which is the best antidote for tension.
Avoidance of excessive emotional tension which leads to personal ineffectiveness.
Mutual loyalty of friends and family.
Pride in a job.
Participation in community affairs.
Continued expansion of knowledge, wisdom, and experience, which add to maturity.

Welfare Payments for Hospitalization on Cost Basis

The Rhode Island Hospital Association has announced that its council on government relations has worked out an agreement between the state and eleven member hospitals of the Association for an entirely new plan of payment, based on cost, for services to welfare patients.

For in-patient services effective July 1, 1958, these hospitals will be paid 90% of their ward cost up to $26 per day and 90% of their cost of infant care up to $10 per day. For ambulatory services existing rates of payment will continue for the present, except for the rate per clinic visit which will be $1.50. The basis for all of the rates is subject to annual review at the request of either party. The substantial increases (from $14 per day, with $3 per infant day paid only after the mother's discharge) were granted by the state on condition that the hospitals voluntarily refrain from requesting supplementary funds from the General Assembly covering the period after July 1. The hospitals included in the new agreement are Kent County Memorial, Lying-In, Miriam, Memorial, Newport, Our Lady of Fatima, Roger Williams General, St. Joseph's, South County, Westerly, and Woonsocket.

From the *Congressional Record—Appendix,* August 25, 1958—

SOCIALIZED MEDICINE IN GREAT BRITAIN A 10-YEAR APPRAISAL

Extension of remarks of HONORABLE THOMAS B. CURTIS of Missouri, in the House of Representatives, Saturday, August 23, 1958

MR. CURTIS of Missouri. Mr. Speaker, I have recently read an editorial which appeared in the July 26 edition of the *Shreveport Times* relating to socialized medicine in Great Britain. The editorial is based on an article which appeared in the *London Economist* wherein the 10-year life span of the program is evaluated by its editors. I insert it in the RECORD for review and consideration by my colleagues.

The editorial follows:

Britain's Ten-Year Flop in Free Medical Care

It was 10 years ago that Britain made every man, woman and child within its domain eligible for free medical and dental service under a program of socialized medicine. The program was so broad that it included everything from hospital care to wigs for the baldheaded.

Socialized medicine was launched in Britain, the *London Economist* reminds its readers in a summary of the results, under promises that it would be no more of a burden on the nation's economy than private medicine and that the benefits would be so great we cannot afford not to have it.

Instead, the *Economist* continues, Britons now have learned that government cannot reduce sickness simply by providing free treatment and that efforts in that direction merely mean that the taxpayers are spending a lot more for medical treatment for everybody than the people spent as paying patients. In other words, socialized medicine has been a flop in Britain both from the economic standpoint and the health standpoint.

Under socialized medicine, the *Economist* continues, the aged and the chronic sick have suffered especially. They have been crowded out of the hospitals. Schoolchildren who need dental care have suffered most in the dental field. They have been pushed aside as dentists treated adults.

Prior to socialized medicine it would have been a national scandal if an old man or woman died in poverty because no hospital would take him in, but this happens far too frequently now, the *Economist* says. Only one hospital—a small one—has been built in the entire British Isles since socialized medicine went into effect. The British Government has moved desperately to try to make the program work, especially to meet the problems of rising costs. The whole effort, the *Economist* says, has been to try to balance the socialized medicine budget, or to expand the scope of its service, without any thought of making certain that value was obtained for what was spent.

To try to keep the bill down, the Government turned first to the expedient of increasing the health service contribution, or tax, paid by the people. It rejected demands and needs for pay increases—even on the basis of increased cost of living—for public health service workers, thus making them a victim of inflation and lowering their standards of living. Finally it began charging patients small fees.

Despite these and other expedients, the cost of socialized medicine in Britain rises steadily to new heights beyond revenues in either taxes or Government contributions available for it.

The *Economist* says that the only answer to the problem of socialized medicine in Britain—aside from abolishing it entirely—rests in charging the people a bigger health tax as their part of the cost, and then charging them higher and higher fees for the service received. In other words, what this means is to get away from the entire principle of socialized or free medical service and establish a Government subsidized system in which the cost per person for subsidy very soon could exceed the cost per person for private health service.

Regardless of what Britain does in connection with its own free medical attention flop, the whole experiment has become the strongest argument that could be presented against socialized medicine in the United States.

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PUBLIC ASSISTANCE CHANGES EXPLAINED BY SOCIAL SECURITY ADMINISTRATION

A Summary Report Issued by the Washington Office of the American Medical Association

STARTING OCTOBER 1, the United States will make available to states the increases voted by Congress in public assistance funds. In preparation for inauguration of the new phases of the program, the Social Security Administration has issued a description of the new legislation to all state agencies administering the public assistance program. Following is a summary of those parts of the description that are of particular interest to medicine.

* * *

How New Formula and Increases Will Affect State Programs

At present the U.S. pays $24 of the first $30 monthly per recipient of old-age assistance, aid to the blind and aid to the permanently and totally disabled. It also pays half of the remainder up to an individual maximum of $60 per month.

Under the new law, the U.S. will continue to pay $24 of the first $30 monthly, but will increase its contribution toward the remainder (up to an average maximum of $65) from a flat 50% to between 50% and 65%. All states will be assured of U.S. help of at least 50% in this upper part of the payments, and the states with relatively low per capita income will receive up to 65%.

At present, states receive from the U.S. $14 of the first $17 per recipient for aid to dependent children, and half of the remainder up to individual maximums of $32 each for the first child and needy adult caretaker and $23 for each additional child.

Under the new system, states will continue to receive $14 of the first $17, but the U.S. contribution toward the remainder (up to average maximums of $30) will be increased to between 50% and 65%, as in the above programs. The exact percentage to which each state is entitled will be determined shortly by Secretary Flemming and published in the *Federal Register.*

"Average" Will Simplify Administration and Help Meet Unusual Needs

The new law provides a different and simpler system for calculating the total public assistance money to which states are entitled. Now to determine the amount subject to Federal matching, each monthly payment must be examined to determine the amount, if any, by which it exceeds individual maximums. Now persons with unusual needs and/or limited resources often get less than they need because of maximums on individual payments.

Under the new plan the maximum amount subject to Federal matching will be determined by multiplying $65 by the total number of recipients in the adult categories and $30 by the total number of recipients of aid to dependent children (providing states match up to the maximum). Within these total amounts the Federal share will be 4/5 of the first $30 per recipient in the adult categories and 14/17 of the first $17 in aid to dependent children; and in the balance of the payments the Federal share will be 50% to 65% depending upon a state's per capita income.

Some states will benefit financially only through the averaging feature, some will benefit from raising the Federal share of the second part of the payment and some will benefit from both of these features.

Changes in Method of Receiving and Spending Medical Care Funds

At present, the U.S. offers states $3 per month per adult public assistance case for medical care costs, providing the states match this money 50-50, and $1.50 per month per child, with the same matching requirement. This money, which is over and above the individual maximums ($60 for adult categories and $32-$32-$23 in aid to dependent children), must be used for vendor payments, i.e., paid directly to doctors, hospitals, pharmacists, dentists, etc. In addition, the states can give the recipients money for their medical costs within the individual maximums.

A number of states have found that under this arrangement they have not been able to take advantage of all the Federal funds available under both the vendor payments and the money payment (to recipients) parts of the Federal sharing formula. Furthermore, the recipient, not the state, was responsible for paying the medical bills.

Under the new system, the concept of a separate accounting of medical care funds is eliminated. The $65 and $30 per month will be for medical care and all other expenses, such as housing and food, and

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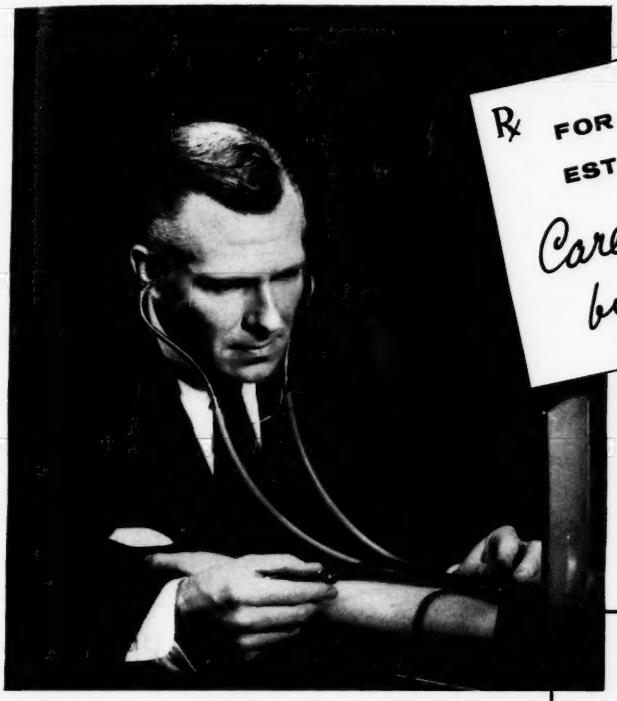

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AMERICAN HOSPITAL ASSOCIATION POLICY ON MEETING HOSPITAL NEEDS OF THE AGED

The House of Delegates of the American Hospital Association, meeting in Chicago late in August, adopted a statement of policy with respect to meeting the hospital needs of the aged. The statement, which supersedes all previous actions taken by the association, follows:

1. The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored, including methods by which the dangers inherent in the Social Security approach can be avoided.

4. It believes that every realistic effort should be made to meet the hospital needs of the retired aged principally through mechanisms utilizing existing systems of voluntary prepayment. However, it is conceivable that the use of Social Security to provide the mechanisms to assist in the solution of the problem of financing these needs may be necessary ultimately.

5. It believes that any legislation developed to provide for government participation to meet the hospital needs of the retired aged should be so devised as to strengthen the voluntary prepayment systems, and should conform to the following principles:

a. Legislation designed to provide for the hospital needs of the retired aged should provide essential hospital services and should exclude custodial care provided for nonmedical reasons.

b. Government participation should be restricted to persons over 65 who are not regularly and substantially employed. The voluntary prepayment system provides a satisfactory mechanism for the coverage of other persons, regardless of age.

c. Any program in which the federal government participates to meet the hospital needs of the nonindigent aged should emphasize individual responsibility and make the application of a means test unnecessary for obtaining benefits.

d. Such a program should be based on the service benefit principle and should provide benefits sufficiently comprehensive to remove the major economic barriers to hospital care for the retired aged.

e. Such a program should make benefits available through non-profit prepayment plans.

f. Hospitals should be paid fully for the cost of care rendered.

g. Such a program should not provide services in facilities operated by the federal government.

h. Such a program should provide reasonable criteria to determine the eligibility of hospitals to participate, but the federal government should be precluded from interfering in the administration and operation of hospitals providing the services.

i. Such a program should maintain the free choice of doctor and hospital by the recipient.

j. Such a program should permit and encourage continuous adaptation to new knowledge in the provision of services.

PUBLIC ASSISTANCE CHANGES

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the states may use any part of these funds to pay doctor and hospital bills. Furthermore, states may pay the money directly to vendors of medical care, they may pay it to the recipients with the understanding it is intended for the vendors, or they may pool the funds, for broad, state-wide programs of medical care.

Explaining this change, the Social Security Administration declares:

> The new federal matching limitation of $65 on total average expenditures will cover both money payments to recipients and payments for medical care on their behalf. Presently, payments to physicians, hospitals and other suppliers of medical care are financed separately from money payments to recipients.

FIRST ANNUAL PHARMACY CLINIC
at the
UNIVERSITY OF RHODE ISLAND
NOVEMBER 18-19, 1958

All Physicians Members of the Rhode Island Medical Society are Invited to Attend the Clinic Sessions

PROGRAM

Tuesday, November 18, 1958

10:30 A.M. ***Auditorium,*** **Quinn Hall**

Presiding: MR. NORRIS GLADDING, *President*
Rhode Island Pharmaceutical Association

Official Opening of the U.R.I. Pharmacy Clinic

DR. HEBER W. YOUNGKEN, JR., *Dean*
College of Pharmacy, University of Rhode Island

Greetings from the University

DR. FRANCIS H. HORN, *President*
University of Rhode Island

10:45 A.M. THE BUSINESS OF PHARMACY AND THE CURRENT ECONOMY

RAYMOND A. GOSSELIN, *President*
R. A. Gosselin Company

11:30 A.M. PROMOTING NEWER TRENDS IN PRESCRIPTION SERVICE

CHARLES C. RABE, *Manager of Special Projects*
J. B. Roerig and Company

12:30 P.M. ***Lunch Hour,*** **New Women's Dining Hall**

2:00 P.M. ***Auditorium,*** **Quinn Hall**

Presiding: DR. HEBER W. YOUNGKEN, JR., *Dean*
College of Pharmacy, University of Rhode Island

2:10 P.M. RECENT ADVANCES IN PHARMACOLOGY—STEROIDS

DR. ALFRED A. RENZIE, *Associate Endocrinologist*
CIBA Pharmaceutical Products Incorporated

2:45 P.M. INSULIN AND ORAL DRUGS IN THE MANAGEMENT OF DIABETES

DR. IRVING BECK, *Department of Internal Medicine*
Miriam Hospital, Providence, Rhode Island

3:30 P.M. ***Pharmacology Laboratory,*** **200 Ranger Hall**

DRUGS AND HYPERTENSION (with demonstration)

DR. JOHN J. DEFEO AND DR. GEORGE J. COSMIDES
Department of Pharmacology, University of Rhode Island

3:30 P.M. ***Pharmacy Dispensing Laboratory,*** **316 Pastore Hall**

THE PHARMACY OF ISOTONIC EYE PREPARATIONS (with demonstration)

DR. SANFORD M. BOLTON AND DR. LEONARD R. WORTHEN
Department of Pharmacy, University of Rhode Island

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FIRST ANNUAL PHARMACY CLINIC

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Wednesday, November 19, 1958

10:00 A.M. ***Auditorium,*** **Edwards Hall**

Presiding: Dr. Pierre F. Smith, *Head*
Department of Pharmaceutical Chemistry
University of Rhode Island

10:15 A.M. RECENT ADVANCES IN THE PHARMACY AND MICROBIOLOGY OF ANTIBIOTICS

Dr. Leonard R. Worthen
Department of Pharmacy, University of Rhode Island

11:00 A.M. PSYCHIC-SYNDROMES AND PSYCHOTROPIC DRUGS

Dr. C. Jelleff Carr
Psychopharmacology Service Center
National Institute of Mental Health

12:30 P.M. ***Lunch Hour,*** **New Women's Dining Hall**

2:00 P.M. ***Auditorium,*** **Quinn Hall**

Presiding: Mr. Henry Mason, *President*
Rhode Island Traveling Men's Auxiliary

2:10 P.M. A NEW LOOK AT DEPARTMENT MANAGEMENT IN THE PRACTICE OF PHARMACY

Professor Joseph H. Goodness, *Director*
Division of Pharmaceutical Administration,
Massachusetts College of Pharmacy

2:45 P.M. A REPORT ON NEW PRICING TRENDS FOR THE NEW ENGLAND AREA

Professor Nicholas W. Fenney
Department of Pharmacy, University of Connecticut

3:30 P.M. PHARMACY LAW AND MANAGEMENT IN RHODE ISLAND PANEL DISCUSSION

Panelists: Dr. George E. Osborne, *Moderator*
Senator Primo Iacobucci
Mr. Joseph Cahill
Mr. Joseph Navach
Mr. Charles Butterfield, Jr.

Note: There will be a discussion and question period following the lecture and panel discussions.

6:00 P.M. ***Pharmacy Clinic Dinner,*** **New Women's Dining Hall**

Summary of the Clinic

Guest Speaker

BOOK REVIEWS

AIDS TO OPHTHALMOLOGY by P. McG. Moffatt. Bailliere, Tindall & Cox, Lond., 1957. 11th ed. Williams & Wilkins Co., Balt., exclusive U.S. agents. $3.00

This book, as its title suggests, is a review book of ophthalmology. It covers briefly, in outline fashion, physical examination, anatomy, some of the more common diseases and some principles of surgery as related to ophthalmology. A few principles of optics are outlined, also. The book is geared toward the general practitioner or to the graduating medical student.

The limitation of the book is its outline form. This, by definition, makes completeness impossible. It is written by an English ophthalmologist and, therefore, the idiom and the therapeutics are British in character. A few of the remedies might be questioned in modern American texts. For example: Leeches are advocated for acute glaucoma; I.M. injections of milk are suggested for a hypopyon ulcer; Salvarsan I.M. and leeches to the temples are advised for sympathetic ophthalmia. The author is a firm believer in heliotherapy and outdoor living as the therapeusis of many ophthalmologic and systemic diseases.

The book, however, is valuable for its conciseness. If, for example, one had to look up an explanation for a common error in refraction, he could find it without undue difficulty in this text. Also, it's interesting to see how medicine is practiced in another country with different medical customs and mores.

The reviewer felt that AIDS TO OPHTHALMOLOGY is of practical value to the medical student desiring a survey approach to the specialty. Anyone desiring detailed information would do well to investigate more complete works on the subject.

DAVID S. KARANSKY, M.D.

HEALTHFUL SCHOOL LIVING. A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the co-operation of contributors and consultants. Charles C. Wilson, M.D., Editor. Wash., Chic. 1957. $5.00

This report of a Joint committee of the National Education Association and the American Medical Association is particularly directed to school administrators and physicians interested in school and child health. In a very excellent manner, it outlines the general concept of school living in a "healthful way."

In the process, it gives an answer to such technical problems as lighting and acoustics, school lunches, prevention of accidents, heating and ventilating. It reaches the other end of the spectrum by touching on academic philosophy and teaching methods.

This book has a limited interest, granted, but it should be of value to those particularly concerned with school health.

JOHN T. BARRETT, M.D.

ORR'S OPERATIONS OF GENERAL SURGERY by George A. Higgins, M.D., and Thomas G. Orr, Jr., M.D. W. B. Saunders Company, Phil., 1958. 3rd ed. $20.00

It is fortunate indeed for the surgical fraternity that the death of Thomas G. Orr, Sr., has not interrupted the editing of ORR'S OPERATIONS OF GENERAL SURGERY. The third edition, prepared by George A. Higgins and Thomas G. Orr, Jr., is in keeping with the excellence of the previous ones.

There is perhaps no finer volume for the surgical intern or resident to use as a base from which to start. The profuse illustrations and concise text will help him in everything from knot tying to technique of multiple viscera resections. The man who has become familiar with such a work will continue to refer to it from time to time but, as an established surgeon, must read further.

While this is a general surgery text, the commoner procedures in urology, gynecology, orthopedics, neurosurgery, and otolaryngology are included. The format of the new edition has been improved by rearrangement of some sections and helpful outlines now precede each chapter. While most of the previous edition is still up to date, new material is added here and there, and there are substantial expansions in the fields of head and neck,

continued on page 588

BOOK REVIEWS

continued from page 586

pulmonary, and cardiac surgery. The 1016 pages contain 1990 step by step illustrations on 835 figures.

THOMAS PERRY, JR., M.D.

ELECTROCARDIOGRAPHY by Michael Bernreiter, M.D. J. B. Lippincott Co., Phil., 1958. $5.00

There are many books available on the subject of electrocardiography. However, far too many are difficult to read, especially in regard to the basic concepts of the subject. This text is clear, concise, and very readable. The fundamental basic principles that are so necessary for understanding of the electrical phenomena responsible for the patterns of electrocardiography, are clearly presented in such a way that the reader need not be a biophysiologist or an electrophysicist to comprehend the subject.

This book will be a great help to the beginner in the field of electrocardiography; either the medical student or the younger medical graduate. It will make interpretation of the electrocardiogram more concise and not force one to resort to the memorizing of set patterns.

The context is brief and to the point. Yet as one reads from subject to subject, one finds the illustrations are profuse and ample to make the point desired by the author. Each pathological condition encountered in electrocardiography is explained on the basis of the electrophysical changes taking place in the myocardium.

This book can be considered another fine contribution to medical literature, especially in the field of teaching; older and experienced electrocardiographers will also find it a refreshing review.

DONALD L. DENYSE, M.D.

THE PSYCHOLOGY OF MEDICAL PRACTICE by Marc H. Hollender, M.D. W. B. Saunders Co. 1958. $6.50

Doctor Hollender and his collaborators, Doctors Stine, Solomon and Richmond, have produced an instructive and eminently practical book. By the expression, the psychology of medical practice, Doctor Hollender means the art of healing, his purpose being to turn a psychological spotlight on the patient, the physician and the medical situation. Throughout the book the main emphasis is placed on the problems encountered in the everyday practice of medicine and what can be done about them. The patient is studied as a person; accordingly, the physical and psychological approaches are intertwined, and the physician is counseled to take what

may be properly called the global, as distinguished from the fractional, view of his patient.

The book is cast, for the most part, in the form of questions and answers, a method which makes for concrete directness and the avoidance of the fuzzy generalities so often found in medical writing. The chapter headings are these: the *Doctor-Patient Relationship*, the *Medical Patient*, the *Patient With Carcinoma*, the *Surgical Patient*, the *Obstetrical Patient*, the *Pediatric Patient in Health*, the *Pediatric Patient in Illness*, *Psychological Considerations in the Use of Medications*, the *Non-medical Prescription*.

Whether your work be that of a generalist or a specialist you will find, in the chapters listed above, a wealth of material which is obviously based upon a wide and rich clinical experience, crystallized by the discipline of teaching. It should be emphasized once again, that this is an eminently practical book from which any physician, young or old, may glean something to interest and much to help him in meeting the problems which confront him daily in the practice of his profession.

JOHN E. DONLEY, M.D.

CRIME AND INSANITY. Edited by Richard W. Nice. Philosophical Library, Inc. N.Y., 1958. $6.00

It is well known to all doctors as well as psychiatrists that no uniformity exists in the determination of insanity in the criminal. Each state as well as the federal government has its own viewpoint in this important phase of justice.

This volume of 280 pages, edited by Richard W. Nice, is an attempt to present fairly these divergent views in the light of our more recent knowledge of psychiatry, psychology, and criminology.

While many views presented are contrary to previously understood concepts, it does orient the court physician with the various viewpoints prevalent at this time.

There is a valuable appendix which is the result of a national survey in which six questions were asked of mental health officials, departments of correction and chief justices of each of the forty-eight state Supreme Courts. These questions had a direct bearing upon the question of a plea of insanity as a defense to a criminal act.

While this book does not attempt to formulate any uniform procedure, it does emphasize the need for some important reforms in many archaic laws presently on the statute books.

This unique volume is a handy reference book for the busy psychiatrist, jurist, or lawyer involved in such important cases.

L. A. SENSEMAN, M.D.

THE AMERICAN MEDICAL ASSOCIATION AND SOCIAL MEDICINE

BY ROYCE BRIER, *San Francisco Chronicle*

SINCE THE WAR, socialized medicine so-called has become one of the foremost controversies in the United States.

The American Medical Association is meeting in San Francisco, and as usual it will discuss various pending proposals for socialized medicine. As usual it will oppose them. As usual many Americans, supported by politicians, will take the doctors to task for this attitude.

Socialized medicine is not primarily a scientific cause, but a political cause. It is a political cause because politicians see votes in it. Politicians see votes in it because most of us are poor, and find it difficult to meet our medical bills. Politicians say socialized medicine will halve these bills, or better.

Politicians are as versed in human nature as are doctors, and when you are versed in human nature you attain to power over human beings. Adolf Hitler was a good example of this, but in a wholly different domain, so was Abraham Lincoln.

It is true that socialized medicine will reduce medical costs for certain segments of the American population, but it does not do this by increasing medical efficiency. It does it by shifting the costs to the general taxpayer.

There is no evidence whatever that socialized medicine will increase efficiency, and there is contrary evidence in Great Britian. The factor involved in the cause is not medicine as an art and a science, but almost exclusively the money of those needing medical treatment—or fancying they do.

Medicine as an art and a science is as competitive as any human institution known. First, those who serve it range from the sloppy to the dazzling, from doltish money grubbers to the creative and self-sacrificing. Second, those needing medical treatment approach it emotionally, and excepting the marital state, nothing is more delicate and personal than the relation between doctor and patient.

This relation cannot be adequately met by a political or social device, any more than the marital relation can be adequately regulated by divorce laws.

The present high and rising cost of medical treatment is in part the high cost of modern technological procedures, and in part the inflationary price structure of our time. The story of a few years ago that doctors were getting the lion's share of medical costs was sheer nonsense, refuted by the most casual examination of any total bill for illness involving hospitalization and latter-day methods of treatment.

The doctors were the target because the politicians saw in them the most vulnerable target, due to the undeniable reality that a good doctor makes a good income. So do good lawyers, but most of us go through life without even needing one. Hence envy of a lawyer's lot cannot be transformed into a political cause.

In the Soviet Union the cost of medical treatment is low. When and if we retrogress to the Soviet standard of living and to the Soviet concept of a collective society without competition, our medical costs will be low, too.

... Reprinted from the *Newsletter* of the Public Relations Committee, California Medical Association, August, 1958.

PROVIDENCE MEDICAL ASSOCIATION MEETINGS

MONDAY, NOVEMBER 3, at 8:30 P.M.

"HYPERTENSION"

Speaker

HAROLD W. SCHNAPER, M.D., of Washington, D. C.

Assistant Professor of Medicine,
Georgetown University Medical Center

* * *

MONDAY, DECEMBER 1, at 8:30 P.M.

"STAPHYLOCOCCAL INFECTIONS" — *A Panel Discussion*

Discussors

PAUL FREMONT-SMITH, M.D., of Boston

Director, Bacteriology and Infectious Disease,
Peter Bent Brigham Hospital

and

CARL WALTER, M.D., of Boston

Senior Surgeon, Peter Bent Brigham Hospital

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Why revive the subject now? Because clinical experience with nonmercurial diuretics indicates most of them have such a specific effect on potassium that with their use very real problems must be faced. Enough potassium loss can lead to digitalis toxicity or to a classical overt hypopotassemia. Since a fair percentage of cardiacs who receive diuretics are also digitalized, this excess potassium excretion is clinically serious. Clinical experience is still too limited with some nonmercurial diuretics to say just how often such loss will occur—but warnings already have been sounded by some clinical investigators as to the need for potassium supplementation.

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LAKESIDE

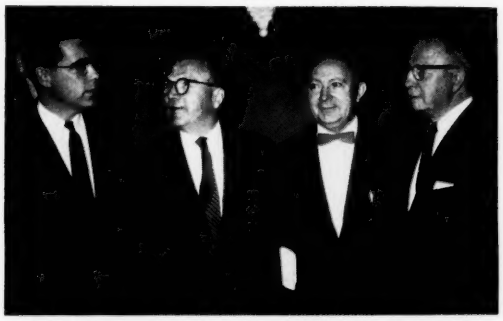
INTERIM MEETING HELD AT NEWPORT

A VERY SUCCESSFUL Interim Meeting of the Rhode Island Medical Society and its Auxiliary was held at Newport, Rhode Island, on Wednesday, October 8, 1958, with approximately 125 in attendance at the scientific sessions at the Newport Naval Hospital in the afternoon, and at the dinner session at the Viking Hotel in the evening. It was the first time since 1952 that the state Medical Society has held a session at Newport.

An excellent series of lectures was arranged by the medical and surgical staffs of the U.S. Naval Hospital with presentations given by Lt. Alfred W. Wolfson, Lt. Edward H. Ray, Jr., Captain J. M. McLaughlin, and Lt. Ralph Nachman, the last named taking the assignment of Comdr. G. T. Van Petten, who had been slated to address the Society. Dr. Francis B. Sargent, president of the Society, presided at the afternoon session.

While the Society members were meeting at the Naval Hospital, the members of the Woman's Auxiliary conducted a business meeting and tea at the White Horse Tavern, after which the group visited the famous "Breakers" before joining their husbands for the social hour and dinner at the Viking Hotel in the evening.

Dr. Samuel Adelson, Newport surgeon and vice president of the Society, presided at the dinner meeting which was addressed by Lt. Comdr. D. H. McLean, who related his experiences as one of a group of twenty-three who laid the groundwork for the Weddell Sea bases in 1946-48, which were used this year in connection with the research activities of many nations as part of the International Geophysical Year program. His lecture was illustrated by some unusual photographs of the group's camp and its surroundings in the Antarctic regions.



SOCIETY OFFICERS AT NEWPORT MEETING

Officers photographed by the *Newport Daily News* while attending the Interim Meeting at the City by the Sea are from left to right: THOMAS PERRY, JR., M.D., *secretary;* FRANCIS B. SARGENT, M.D., *president;* SAMUEL ADELSON, M.D., *vice president,* and ALFRED L. POTTER, M.D., *president-elect.*

CHECK THE DATES NOW!

148th ANNUAL MEETING

of the

RHODE ISLAND MEDICAL SOCIETY

Tuesday, May 12 and Wednesday, May 13...1959